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MINUTES

MONTANA SENATE
51st LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE AND SAFETY

Call to Order: By Chairman Tom Hager, on February 10, 1989,
at 1:00 p.m.

ROLL CALL

Members Present: Senators Tom Hager, Chairman; Tom
Rasmussen, Vice-chairman, J. D. Lynch, Matt Himsl,
Bill Norman, Harry H. McLane, Bob Pipinich

Members Excused: None

Members Absent: None

Staff Present: Tom Gomez, Legislative Council
Dorothy Quinn, Committee Secretary

Announcements/Discussion: Chairman Hager announced that SB
340, sponsored by Senator Bob Williams, and SB 217,
sponsored by Senator Mike Halligan, would both be heard
at the same time since they both address Certificate of
Need.

HEARING ON SENATE BILL 340 AND SENATE BILL 217

Presentation and Opening Statement by Sponsor: Senator Mike
Halligan, Senate District #29, advised that SB 217
removes the Sunset provision on the Certificate of Need
process for health care facilities. He stated one of
the major reasons for this piece of legislation is to
continue responsible health care planning. With the
rural character of Montana, he feels it is absolutely
necessary that the process which protects that rural
focus be continued. One of the things the CON process
does is it looks at the community's needs as opposed to
looking at the provider's needs, which may be strictly
to generate revenue. He stated there is no way to
guarantee quality, accessibility, availability, cost,
and continuity but one of the things this process does
is assure that all of those factors are considered when
a facility is requested. He believes that a free
market has not worked, and it will not work. He
pointed out that Arizona and Utah repealed the CON

Senator Lynch directed the same question to Rose Hughes. She advised that the Montana Health Care Association is strongly supporting SB 217, strongly opposing SB 340, and added that if SB 340 comes out of committee they will continue to oppose SB 340.

Senator Himsl indicated that Arizona was the one state in the union that did not have Medicaid, and had a different type program that collapsed. Senator Himsl asked if Arizona discontinued the CON in 1987. Mr. Lane Basso said he believed it was in 1985. Senator Himsl stated that subsequently Mayo came into Scottsdale and put up a huge clinic there, and it is now a popular center, pointing out that when they were free to come in, they came in.

Senator Hager announced that because the time ran out, those who did not get an opportunity to testify could rise and identify themselves and state whether they support or oppose either bill:

Pat Melby stated that he is an attorney who represents Rimrock Foundation and Broadwater Health Center, Townsend. He stated on behalf of both those facilities he wished to advise the committee that they oppose SB 340 and support SB 217. (Exhibit #16).

Steve Waldron of the Montana Council of Mental Health Centers advised that they are opposed to SB 340 because they are concerned that health care costs will rise so rapidly.

Ed Sheehy, representing the National Association of Retired Federal Employees, stated his organization is opposed to SB 217 and support SB 340.

Fred Patten, representing the National Association of Retired Persons, stated they support SB 217 and are opposed to SB 340. He submitted written testimony (Exhibit #17).

The following persons submitted written testimony in favor of SB 217:

Ron Borgman, Administrator of Stillwater Convalescent Center, Columbus, Montana (Exhibit #18)

Sandra Erickson, Providence Chemical Dependency Treatment Centers, Cascade, Pondera and Glacier Counties (Exhibit #19)

Kristin Rapacz, Administrator, St. John's Lutheran Home,

be allowed to sunset.

Dr. David Klein, a general surgeon practicing in Billings, stated he has been involved with federally mandated health care planning and the Montana CON law since it started 14 years ago. He stated he strongly opposed SB 217, and spoke in support of SB 340. He read and submitted his written testimony to the committee (Exhibit #15).

Questions from Committee Members:

Senator Hager stated that he had a technical question for Senator Halligan. He noted that Section 3 was a repealer, repealing Section 53-6-110, which refers to a report and recommendation to legislators on Medicaid, and asked if that was what Senator Halligan wished to repeal.

Senator Halligan responded by stating he did not know why it was being repealed and referred the question to a Health Department representative.

Dale Taliaferro stated that was put in at the request of SRS. He stated in the last legislature it was inadvertently renewed. It applies to some other processes that they are no longer using.

Senator Hager stated it does not apply to this bill, and they would look into it.

Senator Lynch asked what is the situation going on in Billings. Dr. Dernbach stated that the CON issue would not be such a big thing if it were not for the open heart situation now in Billings. He stated his opinion of the situation was that in 1977 both hospitals reviewed the needs for a new open heart program and they decided there were not enough cases at that time to justify two programs. He gave his opinion of the current situation, but stated this was not the arena to discuss the politics of the hearing process, or the Billings open heart problem.

Senator Lynch asked Larry Akey, Montana Health Network, if SB 217 did not pass, would his group favor SB 340.

Larry Akey replied that is a difficult question for him to answer because he represents hospitals, and 9 of the 10 hospitals he represents have taken the position that hospitals should be continued to be covered by CON. If SB 340 is the only bill reported out of this committee, he was not sure which direction his members would go.

Ray Gibbons, Vice-president of Montana Deaconess Medical Center, spoke in support of SB 340. He stated they feel the CON law should be allowed to sunset, but that SB 340 would be a reasonable compromise. He read and submitted his written testimony to the committee (Exhibits #12a and #12b).

John Johnson, Administrator of Wheatland Memorial Hospital and Nursing Home in Harlowtown, stated he did not care what is going on in other states around Montana, but is interested in Montana concerns. He also stated they do not need another costly regulation to continue to hamper the rural hospitals. He set forth his views in written testimony which he submitted to the committee (Exhibit #13). He stated he is opposed to SB 217, and would like to see the CON eliminated in Montana.

Jim Paquette, President and Chief Executive Officer of St. Vincent Hospital in Billings, advised that they point with pride to joint projects in Billings. However, those facilities are very expensive facilities for which there is not sufficient demand for duplication. That has been done in spite of the CON, through the action of responsible board and management in Billings. He also stated that there is no correlation between CON and cost savings. He advised that Montana ranks 48 out of 51 states in terms of cost per admission, and that is the result of voluntary effort on the part of 42 out of 56 hospitals who subscribe to a voluntary rate review system. He submitted written testimony to the committee which details his concerns (Exhibit #14). He supports SB 340, and opposes SB 217.

Jerry Loendorf, representing the Montana Medical Association, stated that the goal of CON was to control health care costs. If one would judge that law, its history must be studied. He stated by watching the evening news everyone knows health care costs continue to increase at rates considerably more than the Consumer Price Index. The testimony of the proponents indicates there is no cost saving. By examining this history it is evident CON has not worked. He stated another aspect must compare the Boards of Directors of Montana hospitals and their decisions to those of health care planners in Helena. Virtually all of the hospitals in Montana are non-profit, privately operated and directed by a board composed of citizens from the communities where they are located. These citizens were making decisions concerning their hospitals long before CON laws were in effect, and seemed to be making them responsibly. He sees no reason why they would not continue to make responsible decisions should the CON

assured, cost containment is not questioned. He is in favor of doing away with CON altogether; however, he would support SB 340. He presented written testimony which is attached (Exhibit #9).

Lawrence McGovern, Director of Montana Associated Physicians of Billings, advised that theirs is an 87 member physician organization whose practices employ approximately 350 people. It is their opinion that elimination of the expensive, time-consuming, counter productive CON process for hospitals will not only improve access to the regional centers for the rural component, but will help the problems they are facing in Billings. He submitted and read his written testimony to the committee (Exhibit #10).

Jerry Beaudette, Administrator of Sheridan Memorial Hospital in Plentywood, advised that he was formerly administrator of Big Sandy Medical Center. As a representative of the hospital board and medical staff of the Sheridan Memorial Hospital and Nursing Home, he stated he is in support of the elimination of the entire CON process. He supports Senator Williams' bill because it represents a step towards this goal. He stated he is strongly opposed to SB 217 based on his experiences with the CON process. He advised while at Big Sandy he submitted a request for 20 nursing home beds. According to the Montana Health Plan, the need for Big Sandy was 9 beds. Based on this, the State Department of Health initially denied approval, their reason being that the project would be financially impossible. A special bond election was held and passed 509 to 38. He believes when a community can show that type of support for a project, why should it not have it. In 1985 they finally received approval, but by this time the construction cost had increased by \$100,000, which represents 10% of the total construction cost, in addition to \$25,000 which was spent on preparing and representing the application itself. Within a year of construction all 20 beds were filled and there was a waiting list. He urged support of SB 340.

Dr. Timothy Dernbach stated that he has been a cardiac surgeon in Billings for the past 10 years, and is testifying in support of SB 340. He read and presented his written testimony to the committee (Exhibit #11). He summarized by stating that the Legislative Audit questions the continuance of the CON program beyond June 30, 1989, and that should be taken into consideration.

Nursing Home in Chester, Montana, advised that he is also Chairman of the Montana Hospital Association. He stated he is speaking in support of SB 340 which would continue CON and exempt hospitals for most services, all equipment and all construction. He also spoke in opposition to SB 217 which would leave hospitals under CON and would continue CON forever without any changes. As the administrator of a small rural hospital, he stated he is in a position that does not allow him to make unwise business decisions regarding capital investments. He found his experience with CON time consuming and expensive use of resources, and a duplication of process. These programs delayed implementation until the application could go through lengthy unnecessary cycles. He did not deny that health planning is beneficial, but the needs within individual communities will determine whether or not additional health care facilities should be constructed or whether additional equipment should be purchased. All hospitals must make decisions on capital investment in a businesslike manner. Questions asked by hospital administrators as they determine the need for their projects or programs are the same as those questions asked by the CON application. This duplication only adds to the rising cost of health care and creates another obstacle in the efforts of hospitals to run an efficient operation. He stated they refer several patients each year to larger hospitals for services they do not provide. He added that the CON process is no longer effective for Montana's hospitals. He stated that ideally the sunset of the CON law would be in the best interest to all health care institutions. He urged the defeat of SB 217. If a compromise must be made, he would support SB 340.

Dr. Hollis Lefever, Lewistown, Montana, stated he is speaking in support of SB 340. He read and submitted his written testimony to the committee (Exhibit #8). His observations were based on his experience in the private practice of medicine. He asked that CON be eliminated for acute care facilities and providers in Montana.

Jerry E. Jurena, Administrator of Trinity Hospital in Wolf Point, advised that he has gone through this process three times in other states. He stated that each time he found it costly, creates delays, and is very restrictive as to the original plans. He feels the community is the best judge of their needs. He stated they must first get the community support and funding, then they go to the CON. He stated once CON approval is received, that is the last contact. Quality is not

cover the cost of suffering from the illness. He urged that they not remove another safeguard which protects the mentally ill from the escalating costs and allows them to get a certain amount of treatment. He urged passage of SB 217.

Mona Jamison appeared in support of SB 217 on behalf of Rocky Mountain Center of Great Falls. She advised that she is a practitioner in this field and has represented Rocky Mountain and other clients. The process works, according to Ms. Jamison, and has been improved since last session when the act was amended to change the procedures after applications were filed. She explained the hearing process, stating it has saved money for the applicant as well as the state. Relating to the costs of CON, she indicated that if it is eliminated, there will just be a transference of costs not a saving. It will be shifted to the taxpayers of the state through the Medicaid budget and insurance costs. She also pointed out that the criteria that are established in the CON law and in the regulations - need, duplication of services, joint planning efforts, access and availability of services, and financial feasibility, comprise a process that allows people to present information to the Department on both sides of an application. She stated the supporters of SB 217 are the nursing homes. They go before the Department most frequently with applications for new homes or expansion of services. Many of them are denied, yet they are the proponents of this bill because they realize if there are empty beds in any of the facilities, costs go up. She believes SB 217 is vital and urged its support.

Proponents of SB 340:

Jim Ahrens, President of the Montana Hospital Association, stated he wished to make it clear that the Association's support of SB 340 is a result of a Board decision and not all hospitals across the state are represented in that decision. He stated their primary position is to allow CON to sunset. That is what his group prefers, but they support SB 340 which simply removes hospitals from the CON statute. He stated SB 340 is a reasonable compromise. He read and supplied his written testimony to the committee. His exhibit also includes letters from many hospitals whose representatives were unable to attend the hearing (Exhibit #7). He urged support of SB 340 and defeat of SB 217.

Richard Brown, Administrator of Liberty County Hospital and

Association

Charles Aagenes, Department of Health and Environmental Sciences

Kyle Hopstad, Administrator, Deaconess Hospital, Glasgow

George Fenner, Chemical Dependency Programs of Montana

Keith Wilson, Lantis of Montana

Lane Basso, Deaconess Medical Center, Billings

Chuck Butler, Blue Cross and Blue Shield of Montana

Mona Sumner, Rimrock Foundation, Billings

David Cunningham, Rimrock Foundation, Billings

Tom Posey, Alliance for the Mentally Ill

Mona Jamison, Rocky Mountain Treatment Center, Great Falls

Proponents for SB 340:

James Ahrens, Montana Hospital Association

Richard Brown, Liberty County Hospital, Chester

Hollis Lefever, M.D., Montana Medical Association

Jerry Jurena, Trinity Hospital, Wolf Point

Lawrence McGovern, Montana Associated Physicians

Jerry Beaudette, Sheridan Memorial Hospital, Plentywood

Dr. Timothy A. Dernbach, Billings, Montana

Ray Gibbons, Montana Deaconess Medical Center, Billings

John Johnson, Wheatland County Memorial Hospital

James T. Paquette, St. Vincent Hospital, Billings

Jerry Loendorf, Attorney, Montana Medical Association

David Klein, M.D., Billings, Montana

Testimony:

Proponents of SB 217:

Rose Hughes advised that she is Executive Director of the Montana Health Care Association which represents 80 skilled and intermediate care facilities throughout the State of Montana. She stated they represent 24 of the state's 34 hospital/nursing home combination facilities. She said her group supports SB 217 because it believes that the State of Montana and its health care providers have an obligation to the people of Montana to use its very limited health resources wisely. She read and submitted her written testimony to the committee (Exhibit #1), and urged support of the bill.

Charles Aagenes stated he is Chief of the Health Planning Bureau of the Department of Health and Environmental Sciences which Bureau is responsible for administering the CON program in Montana. SB 217 provides for the renewal of the CON law. He read and submitted his

process and they have experienced an overabundance of beds, skyrocketing costs, and problems of rural availability of health care services. He advised that 39 states currently have CON; three others have moratoriums either on capital construction or have strict caps on spending. The CON process is a necessary check and balance in the health care service and delivery system. He stated we cannot afford not to have it.

Senator Williams, Senate District #15, stated he is pleased to be the sponsor of SB 340, along with approximately 50 other Senate and House members. SB 340 does not eliminate CON for all health care facilities, even though there is considerable support to do so. SB 340 simply exempts hospitals, which is a needed compromise. He stated this does not mean that a hospital can now open a nursing home without going through the CON process because under this bill ambulatory surgical centers, home health programs, nursing home beds, in-patient mental health programs, chemical dependency treatment programs and rehab beds will still be covered. All other services as they relate to hospitals are exempt. In explaining why hospitals should be exempt, he stated that CON law was first enacted in 1975 as a cost-control device. At that time Medicare and Medicaid were reimbursing hospitals for their costs. There was little incentive for hospitals to control costs. Today Medicare and Medicaid reimburse on a DRG based system. The DRG system assigns a code number to each patient based on the physician's diagnosis. Medicare and Medicaid pay a fixed amount per DRG regardless of the length of stay, complications, and so on. In effect, Medicare and Medicaid have replaced the CON process as a cost control device. The Legislative Auditor's report released recently is the best evidence available to exempt hospitals while continuing to review the projects of other health care facilities. One final fact should be clearly understood - Montana is the only Rocky Mountain state with the CON law. States such as Wyoming are not experiencing any of the so called fears that may be heard today. He stated he believes this legislation will not be harmful to rural hospitals. This bill is a compromise, exempting acute care facilities from the costly and unnecessary process.

List of Testifying Proponents and What Group they Represent:

Proponents for SB 217:

Rose Hughes, Executive Director, Montana Health Care

Billings (Exhibit #20)

Jean Johnson, Executive Director, Montana Association of
Homes for the Aging, Helena (Exhibit #21)

R. Joseph Rude, Health and Marketing, West, Billings
(Exhibit #22)

The following persons submitted written testimony in favor
of SB 340:

William J. McDonald, Assistant Vice-President, Corporate
Services, Community Hospital, Missoula (Exhibit #23)

Jack Tenge, Member of the Golden Care Plus Board, St.
Vincent Hospital, Billings (Exhibit #24)

In addition, a 43-page Petition with 725 signatures showing
support for SB 340, was submitted to the committee.

Closing by Sponsor: Senator Williams thanked all the
supporters of SB 340. He stated that this bill
contains two major provisions - (1) extends the
Certificate of Need for two more years for the ones who
want it; and (2) it removes the hospitals from the
requirements of CON for certain types of expenditures.
He submitted Exhibit #25, and urged support for SB 340.

Senator Halligan stated that the state has seen what
deregulation has done to the airlines and railroads.
He believes that is how the sunset of the CON will
affect the consumer in Montana. He stated no consumer
groups testified on behalf of SB 340. There were ten
applications to the Department in 1988; 7 were
approved, 1 withdrawn, 1 was denied and 1 is still
pending. The one that was denied was for St.
Vincent's. According to Senator Halligan, the process
seems to be working. Deregulation in this heavily
subsidized industry through Medicaid and Medicare is
not free enterprise. The CON process should not be
measured totally by the reductions in cost. It is
accessibility and availability of services where rural
states and small communities need the protection, and
that is where CON plays the major role. He hopes that
with some regulation through the CON, costs will be
controlled. He stated SB 340 is not a compromise bill
because the consumer needs to be the person to be
considered.

DISPOSITION OF SENATE BILL 217 AND SENATE BILL 340

Discussion: Senator Hager announced that Executive Action
would be taken on these bills on Monday, February 13,
1989, commencing at 12:45 p.m.

MONTANA HEALTH CARE ASSOCIATION

EXHIBIT NO. _____
DATE 2/10/89
BILL NO. 340



February 10, 1989

36 South Last Chance Gulch, Suite A
Helena, Montana 59601
406-443-2876

SENATE BILL 340

SENATE PUBLIC HEALTH COMMITTEE

For the record, I am Rose Hughes, Executive Director of the Montana Health Care Association, an association representing some 80 skilled and intermediate care facilities throughout the State of Montana. Included in our membership are county and religious affiliated facilities, private for-profit facilities, and facilities co-located with hospitals. In fact, we represent 24 of the state's 34 hospital/nursing home combination facilities.

The Montana Health Care Association opposes Senate Bill 340 because it believes that the State of Montana, and we as health care providers, have an obligation to the people of Montana to use its very limited health care resources wisely.

Health planning and the certificate of need process are the only protection the State of Montana has in place to protect consumers from the high costs associated with unnecessary investment in health care facilities, duplication of health services, and the high price that accompanies this excess capacity and duplication.

Senate Bill 340 asks you to make a sham of responsible health planning, by removing from the process the single largest provider of health care services, and the provider of the most

PUBLIC HEALTH

COMMITTEE

51st LEGISLATIVE SESSION -- 1989

Date

SB 217
SB 340
2/10/89

NAME	PRESENT	ABSENT	EXCUSED
Sen. Tom Hager	X		
Sen. Tom Rasmussen	X		
Sen. Lynch	X		
Sen. Himsl	X		
Sen. Norman	X		
Sen. McLane	X		
Sen. Pibinich	X		

Each day attach to minutes.

expensive health care services--hospitals. You're being asked to accommodate the convenience of these hospitals at the expense of Montana's consumers and taxpayers, the very people you're here to serve and protect.

The major goal of certificate of need is cost containment--the process attempts to prevent unnecessary capital expenditures and duplication of services, which cause substantial increases in the per service cost of health care.

The fastest growing segments of our state Medicaid budget are:

- ...inpatient hospital services, which grew 70.63% from FY85 through FY88

- ...outpatient hospital services, which grew 126.52 % from FY85 through FY88, with the "cost per service" growing 40% from FY87 to FY88; and

- ...inpatient psychiatric care for youth, which the Legislative Fiscal Analyst describes as the "fastest growing segment of the primary care budget" with an increase from FY88 to FY91 of 106%.

These three fastest growing segments of the Medicaid primary care budget would all be exempt from the certificate of need process under Senate Bill 340.

When any one sector of the health care system is allowed to waste limited resources, all parts of that system, as well as the consumers suffer.

Those of us who have spent much of the past month downstairs participating in hearings on the human services budget know that the dollars available to pay for health care for the poor are very limited. There simply are not funds available to pay for all the needs that are being identified. The committee has had to consider eliminating optional Medicaid services such as

speech, occupational and physical therapy, as well as services provided in our mental health centers. The subcommittee made a very difficult decision not to fund a salary upgrade for nurse aides caring for the frail elderly in our nursing homes, yet no one on that committee believed that these people don't deserve increased wages. It was simply a matter of allocating limited resources.

As that process unravels downstairs, all who participate in it become painfully aware that wasteful spending in any one of those programs affects the funding of all other services. If you allow the hospitals to do as they please, and they expand and duplicate services, as has happened in other states, that will affect the ability of the legislature to fund not only hospital services but all other health care services. That is why you find that most providers of health services in this state oppose your giving in to the demands of the hospitals in this state to do as they please.

Earlier, I presented information about the affects of lack of CON on nursing homes in Arizona and Utah. Let me give you some statistics about what has happened with hospitals in those states.

In Arizona, since deregulation of hospitals in March 1985, proposed projects include construction of 14 new hospitals representing 1,285 beds at a cost of \$169.4 million, and the expansion of existing hospitals by 238 beds at a cost of \$19 million. This is happening despite the fact that hospital utilization was already decreasing at the time deregulation occurred. And, although hospital utilization has dropped as

bed capacity has increased, hospital revenues have steadily risen. Consumers in Arizona are simply paying more money for less utilization, which is exactly what occurs when health facilities over-build.

A related effect of hospital deregulation in Arizona has been a marked increase in hospital-based tertiary specialty services in 1985, including 6 new open heart surgery programs and 3 additional cardiac catheterization laboratories. These new services brought significant upward trends in overall utilization. Nine physical plant expansions entail a cost of over \$30 million.

The expansion of high-tech equipment was also evident in Arizona. Arizona now has 10 nuclear magnetic resonance imaging systems (MRI) serving a population of 3.1 million people, including 4 freestanding units. The total cost exceeds \$15 million.

The State of Arizona estimated in late 1985 that consumers in that state were spending in excess of \$225 million a year for excess hospital capacity and concluded that continued expansion of the health system would pose significant problems in the area of cost containment.

In Utah, termination of CON brought with it an influx of providers and new beds in the area of free-standing psychiatric hospitals. From January 1, 1985, to September 1, 1988, 8 new free-standing psychiatric hospitals have been built in the state for a total of 550 new licensed beds. Although one or two psychiatric hospitals may have actually been needed, it is generally thought that there is now substantial excess of such

beds. Occupancy rates are low for most of these facilities.

There is not much question that the experience of states without a certificate of need process has been the expansion of health services of all types--nursing home beds, hospital beds, psychiatric and specialty hospitals, high tech equipment, and the like. When this happens, consumers are pushed to consume more health services than they need, and the cost of those services goes up.

I hope you will compare the broad based group of consumers and providers who support responsible health planning and certificate of need for all major services to the narrow interests of those who are inconvenienced by the process and would like to exempt themselves from it.

We urge you vote "do not pass" on Senate Bill 340, as being against the best interests of the consumers and taxpayers of this state.

PH. 322-5318

Stillwater Community Hospital

P.O. BOX 959

COLUMBUS, MONTANA 59019

February 9, 1989

Mr. Jim Ahrens
President
Montana Hospital Association
1720 Ninth Avenue
P.O. Box 5119
Helena, MT 59604

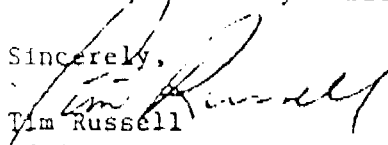
Dear Jim:

In the debate over the CON issue I would like to lend my support of SB 340. The ability to manage small hospitals in an efficient and effective manner is difficult enough, without the cost and burden of the CON legislation. The ability to stay afloat as a hospital should be reflected in equitable reimbursement for quality service as is the case in other businesses and not dependent on a service secured by the CON.

There are services where I feel the patient might be better served by retention of the CON. It is far more appropriate to address those areas with an exemption rather than requiring all hospital services to adhere to the CON.

If I can be of any assistance please give me a call.

Sincerely,


Tim Russell
Administrator

P.S.

I did have a chance to speak with Senator McLane on this issue today.

St. James Community Hospital, Inc.

Office of the President

February 9, 1989

TO: Montana Hospital Association

FROM: Sister Loretto Marie Colwell *LM*
President
St. James Community Hospital

RE: CERTIFICATE OF NEED

St. James Community Hospital staff supports the elimination of hospitals from the CON process.

In today's milieu of continued decline in financial reimbursement and present governmental regulation, hospitals will be severely limited in their ability to increase services.

We are of the opinion that very few, if any, facilities would unnecessarily duplicate or create services in their service areas in the present and projected future health care environment.



February 9, 1989

Senate Public Health Committee
Capitol Building
Helena, MT 59601

Dear Ladies & Gentlemen:

I am writing to you as President of St. Peter's Community Hospital in support of SB 340 which would remove hospitals from the provisions of current Certificate of Need regulations.

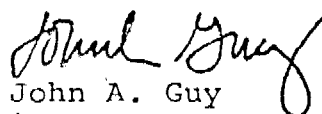
Certificate of Need legislation was mandated by the Federal Government in Montana and other states at a time when hospitals were reimbursed for Medicare and Medicaid patients based upon their level of expenditures. That system did not provide a great deal of incentive for hospitals to contain costs. Consequently, the Certificate of Need process was probably a good idea to ensure that major capital expenditures underwent appropriate scrutiny.

Since 1983, hospitals have been under a different reimbursement system for Medicare and Medicaid patients known as prospective payment. Under this system, hospitals are reimbursed a fixed amount based upon the patient's diagnosis. Those hospitals which spend more treating a patient than is allowed under this fixed payment system lose money. Therefore, hospitals now pay very close attention to their operational efficiency and to their capital expenditures.

Under our present reimbursement system, the Certificate of Need process is superfluous. It simply does not make good economic sense to expand facilities, services and technology that cannot be cost justified. Today the laws of economics are sufficient to drive decision making in the health care market place. We no longer need the added burden and cost of the Certificate of Need review process to tell us the obvious.

Thank you for your consideration.

Sincerely,


John A. Guy
President

JAG/jjf

TESTIMONY TO THE SENATE PUBLIC HEALTH COMMITTEE SB 217 + 310

SENATE BILLS 217 AND 340

February 10, 1989

Mr. Chairman, members of the Committee, I am James Ahrens, President of the Montana Hospital Association. The Hospital Association represents 54 hospitals and 31 nursing homes of all sizes across the state. It is the position of the Montana Hospital Association to allow Certificate of Need (CON) to sunset. While we would prefer to see the entire law terminate, we support Senate Bill 340, which would simply remove hospitals from the CON statute. We believe the Williams Bill is the reasonable compromise. It is the middle ground between sunseting the law and continuing the law in perpetuity without any changes.

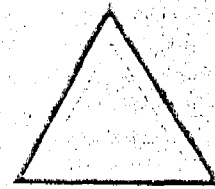
Before I begin my remarks in favor of SB 340, I would like to say a few words about SB 217 and what I view as serious flaws in the bill. The most significant flaw is the removal of a sunset provision. When CON was reauthorized in 1987, the Legislature directed a legislative audit of the program. That report was released Wednesday, February 8, 1989, to the Legislative Audit Committee. That independent report concluded, "In summary, it is difficult to ascertain whether Montana's CON program has been effective enough to continue the program beyond June 30, 1989." This is a less than ringing endorsement of a program which has been in effect in Montana for 14 years, and yet SB 217 would reauthorize the law without any programmed legislative oversight. It is a fairly common occurrence for legislatures to program sunset provisions into regulatory bills, simply to periodically look over the shoulders of the regulatory agency. It seems even more appropriate with CON; the Legislative Auditor questions its effectiveness, the two major proponents of CON are the regulators, meaning the Department of Health, and the regulated, meaning the nursing home industry. We believe CON, if it is to be continued, should be reviewed every two years. The number of deregulated states grows every year, and the Legislature should avail itself of new information on the effects of deregulation.

The Legislative Auditor's report is a fair and dispassionate document, and I recommend you read and share the report with your colleagues. In its discussion of the effects of deregulation in states that have terminated CON, it states that there was a "rapid expansion and new construction of health care facilities, (in Wisconsin, Arizona, Utah, New Mexico, and Colorado), the most drastic being hospital and nursing home bed increases, and new psychiatric hospitals." The report goes on to say that in Wyoming, Texas, Kansas, and Idaho, there were "No drastic increases or changes." The question to consider is whether Montana is more like Arizona, Colorado, and Utah, or more like Wyoming and Idaho. Arizona and Colorado are obviously growth states. The major growth area in Arizona is among the elderly. One has to ask whether or not there would have been dramatic growth in health care services in Arizona, even if CON were in place. Interestingly, the nursing home industry in Arizona attempted to reinstate CON earlier this year, and the Arizona Legislature said no. The Colorado Legislature turned back a similar attempt. Utah has the fastest rate of natural population increase of any state in the country. It is clear Montana is more like Wyoming and Idaho, two states that have terminated CON with "no drastic increases or changes" (Page 22 of the Legislative Audit Report, released February 8, 1989).

The simple facts are these: No one can prove that over the last 14 years CON has reduced health care costs. No one can prove that the removal of CON controls will increase costs. The federal government and twelve states have come to the conclusion that it does nothing and have decided to stop spending limited monies on

MONTANA HEALTH CARE ASSOCIATION

SENATE BILL 340 - HEALTH & WELFARE
EXH. 1
DATE 2/16
BILL NO. 340



36 South Last Chance Gulch, Suite A
Helena, Montana 59601
406-443-2876

SENATE BILL 340 - To Remove Hospitals from the Certificate of Need Bill

You are being told that there is a trend toward deregulation of the health care industry. In fact, the vast majority of states have retained a certificate of need process or other stringent regulatory scheme in an attempt to control rising health care costs.

States with CON process in place: 38 states & D.C.

Alabama	Maine	North Dakota
Alaska	Maryland	Ohio
Arkansas	Massachusetts	Oklahoma
Connecticut	Michigan	Oregon
Delaware	Mississippi	Pennsylvania
District of Columbia	Missouri	Rhode Island
Florida	Montana	South Carolina
Georgia	Nebraska	Tennessee
Hawaii	Nevada	Vermont
Illinois	New Hampshire	Virginia
Indiana	New Jersey	Washington
Iowa	New York	West Virginia
Kentucky	North Carolina	Wisconsin

States without CON: 13 states

Arizona	Utah	Colorado
Idaho	Kansas	Wyoming*
Minnesota*	Texas	Louisiana
New Mexico*	California	Wisconsin*
South Dakota		

*These four states are without CON but have imposed other restrictions on growth. They have not allowed the "free market" to set health care costs. Minnesota currently has a moratorium on nursing home and hospital beds. Wisconsin has a similar moratorium. New Mexico has imposed regulations which discriminate against new providers, a low cap on capital costs, to keep growth down. And, Wyoming has a similar lid on capital costs as well as pending legislation for a moratorium on new beds.

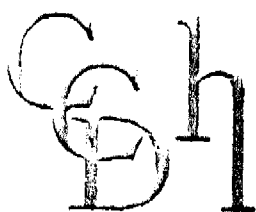
PLEASE SUPPORT CERTIFICATE OF NEED FOR ALL HEALTH CARE PROVIDERS,
INCLUDING HOSPITALS.

For more information, contact: Rose M. Hughes, Executive Director

An Affiliate of

ahca

American Health Care Association



Chouteau County
District Hospital

February 9, 1989

Anthony L. Wellever, Senior Vice President
Montana Hospital Association
P.O. Box 5119
Helena, Montana 59604

Dear Tony:

It was my intention to be present for the CON hearing on February 10th, however, I will be unable to do so.

Please be advised that this facility strongly supports the Williams Bill (SB340) pertaining to the Certificate of Need.

We feel that the CON is burdensome, expensive, and counter-productive in it's present state.

Sincerely,

Robert E. Smith
Administrator

BARRETT MEMORIAL HOSPITAL

1260 South Atlantic
Dillon, Montana 59725
406-683-2324

February 9, 1989

MEMO TO: Senate Public Health Committee
FROM: Ray Worthington, Administrator
REGARDING: Senate Bill 340, Senator Bob Williams, sponsor

This message is to register our support for Senate Bill 340 which would continue the Certificate-of-need (CON) for two more years and exempt hospitals for most services, all equipment and all construction. We understand that Senate Bill 340 would require that hospitals obtain a CON for swing beds, long term care beds, psych, rehab and CD services, and that home health, hospice and personal care would also require a CON.

Rural hospitals, especially, need to assertively position themselves to provide the space and equipment needed to provide the appropriate medical services for their community. Boards and Administrators need to act in a timely manner. The CON process is lengthy and consuming of both time and energy that would be better spent in well directed strategic planning within the communities. Construction projects and equipment purchases should not be hampered with the CON process.

At Barrett Memorial Hospital in Dillon we are working with our physicians and the community in a strategic planning process to assure that the necessary medical services are provided for Beaverhead County for years to come. DECISION MAKING ABOUT CONSTRUCTION AND EQUIPMENT NEEDS TO HAPPEN LOCALLY.

We have enjoyed an excellent relationship with the State Department of Health as we worked through the CONs for our home care service and our swing beds. Their help with the policies and procedures was invaluable. Therefore we can support the continuance of CON for the addition of such services.

A handwritten signature in dark ink, appearing to read "Ray Worthington", is written over a faint, circular, dotted-line stamp.

**NORTHERN
MONTANA**
Hospital

P.O. Box 1231 50 Thirteenth St. Helena, MT 59601

(406) 265-2211

February 9, 1989

Mr. Jim Ahrens, President
Montana Hospital Association
P. O. Box 5119
Helena, MT 59604

RE: Certificate of Need Hearing February 10, 1989

Dear Jim:

I am sorry that I will not be able to be present to testify with reference to our thoughts on the two specific Bills before the Senate Public Health Committee. One calling for continuing of the CON for two more years and exempting Hospitals for most services, all equipment, and all construction, Senate Bill #340, which as I understand it is sponsored by Bill Williams, and the other Senate Bill #217, which as I understand it eliminates the Sunset provision and leaves hospitals under CON.

We certainly support releasing hospitals from the CON, and have serious reservations with regards to any elimination of Sunset provisions, leaving the present CON forever in place as it presently exists without changes. As I wrote to our Senator Greg Jergenson, on December 19, 1988, and others in our area of the State, the whole process is extremely expensive, we're the only state in our region not to have already done away with it, and no matter what the struggle or issue the history of the system thus far has been such that an individual institution if it has enough money and the right lawyers can get what they want with the existing process or through the courts. It would seem then that its time has come, and the free market forces should be allowed to work, and the Certificate of Need be removed from hospitals at least, if not entirely.

With reimbursement to hospitals and those in the healthcare industry today being what it is, it would be only foolish to build or overbuild in an area where the market place will not financially support it. Why should Montana that is already strapped with too many rules, regulations, costs, plans, bureaucracy, etc., be different than all of its neighboring states who have succeeded to move ahead without the Certificate of Need, place additional costs on hospitals to support a State agency to do what basically is unnecessary to be done, at the expense of those who pay the bills, the patients, because of the increased costs caused by such an outmoded system.

Personally, I think the CON should be allowed to sunset. But certainly, hospitals should be allowed to be out from under the system, and the Williams Bill, #340, would allow, and allow the individual Boards of Trustees, whose job it is determine the fate of their institutions, to determine what they will do or not do for their communities. Thank you.

Best Regards,

Gerald W. Bibo
Gerald W. Bibo

Community Hospital of Anaconda

401 West Pennsylvania AND NURSING
Anaconda, MT 59711
(406) 563-5261

HOME



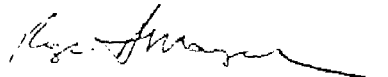
February 8, 1989

Mr. James Arhens, President
Montana Hospital Association
17 29th Avenue
P.O.Box 5119
Helena, Montana 59604

Dear Jim,

The purpose of this letter is to formally advise you that our hospital is in total support of Senate Bill 340 introduced by Senator Williams for the main purpose of sunseting the Certificate of Need Program for Hospitals. At the same time we are in total opposition to the Senate Bill 217 introduced by Senator Halligan which infact would continue the Certificate of Need Program for Hospitals. Our experience has been that the Certificate of Need Program is a cumbersome and non-effective effort to control capital expenditures by Hospitals instead of allowing the market place control the capital expenditures of Hospitals.

Sincerely,


Roger H. Mayers, CEO

RHM/my

Roundup Memorial Hospital and Nursing Home

P. O. Box 627
Roundup, Montana 59072

Feb. 8, 1989

Mr. Anthony L. Wellever, Senior Vice President
Montana Hospital Association
P. O. Box 5119
Helena, Montana 59604

Dear Mr. Wellever:

In reference to the Certificate-of-Need Hearing to be held on Feb. 10, 1989, I am writing in support of the Williams Bill which would exempt hospitals for most services, all equipment and all construction.

With the regulations imposed upon hospitals at this time, the Medicare reimbursement, as it is, and the shortage of some professionals to staff a facility, I do not feel there will be an interest in any new construction of hospitals, except what is a necessity.

At Roundup Memorial Hospital, our patients are largely Medicare patients and I think this is typical of a lot of small, rural hospitals. Due to the reimbursement on Medicare patients, hospitals are not a profitable business to get into. Hospitals cannot financially buy equipment beyond what is justified, so I do not feel the CON is needed for equipment.

The CON is costly, and is another example of what drives hospital costs up.

I strongly support hospitals being eliminated from the Certificate of Need process, except for swing beds, LTC beds, psych, rehab, and CD services as listed in the Williams Bill.

Thank you for your efforts on behalf of Montana hospitals.

Sincerely,

Fern E. Mikkelsen

Fern E. Mikkelsen
Executive Director



Teton Medical Center

915 Fourth Street Northwest
P.O. Box 820
Choteau, Montana 59422
(406) 466-5763

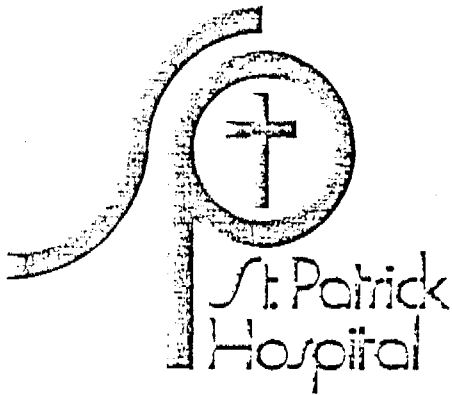
Montana Hospital Association
Box 5119
Helena, Montana 59604

Dear Tony and Jim:

I am very concerned with the Certificate of Need issue. I would like to go on record stating that I support Senate Bill 340 and oppose Senate Bill 217.

Sincerely,

Rosalyn R. Bushman
Administrator



February 8, 1989

The Honorable William E. Farrell
Capital Station
Helena, MT 59620

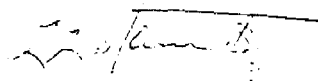
Dear Senator Farrell:

I would like you to know our support for Senate Bill 340,
"Exemption of Hospitals from the Certificate of Need Law".

Currently Montana is the only state in the Rocky Mountains
which continues to have Certificate of Need Laws for hospi-
tals. Seventy-five percent of the hospitals within the state
of Montana endorse the exemption of hospitals from the Certi-
ficate of Need Law.

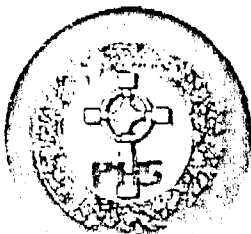
Thank you for your consideration in this matter. If you have
any questions in this regard, please do not hesitate to call
me.

Sincerely,


Lawrence L. White, Jr.
President

cc: James F. Ahrens, President

also sent to: Senator Michael Halligan
Senator William Norman
Senator R.J. Pinsoncault
Senator Robert Pipinich
Senator Fred Van Valkenburg



St. Joseph Hospital

(406) 883-5377 P.O. Box 1010 Polson, Montana 59860-1010

February 8, 1989

Jim Ahrens
Montana Hospital Association
P.O. Box 5119
Helena, MT 59604

SUBJECT: Support of Senate Bill #340 (Williams Bill)
Oppose Senate Bill #217 (Halligan Bill)

Dear Jim,

I, and St. Joseph Hospital, Polson, Montana, would like to go on record as opposing Senate Bill #217 (Halligan Bill) on certificate of need for Montana hospitals.

I, and St. Joseph Hospital, Polson, Montana, would support Senate Bill #340 (Williams Bill). We have expressed our wishes to our representative, John Mercer of Polson.

Sincerely yours,

Fred P. Summary

Fred P. Summary
Administrator/CEO

dew

Rotary Hospital
Billings, Montana

Griffith County
Health Center, Inc.
Jordan, Montana

Shared Services
Sioux Falls, South Dakota

Kennan Hospital
Sioux Falls, South Dakota

Leake's Hospital
Sioux Falls, South Dakota

Joseph Hospital
Sioux Falls, South Dakota

St. Mary's Memorial Home
Sioux Falls, South Dakota

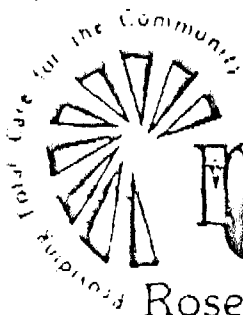
St. Joseph Manor
Sioux Falls, South Dakota

Franklin County
Memorial Hospital
Sioux Falls, South Dakota

Marshall County
Memorial Hospital
Sioux Falls, South Dakota

Dickey County
Memorial Hospital
Sioux Falls, North Dakota

A. L. Vadheim
Memorial Hospital
Sioux Falls, Minnesota



Rosebud Health Care Center

DATE: February 8, 1989

TO: Montana Hospital Association
FAX 406-443-3894

FROM: Joyce Asay, Administrator
Rosebud Health Care Center

RE: CON legislation

Please list me as being in support of Senator Williams SB 340.

I am in opposition to Senator Halligan's SB 217.

Thank you.



Columbus
Hospital

Established in 1892 by Sisters of Providence

500 15TH AVENUE SOUTH • P.O. BOX 5013
GREAT FALLS, MONTANA 59403 (406) 727-3333

February 7, 1989

Senator Jerry Noble
Montana State Senate
Capitol Station
Helena, MT 59620

Dear Jerry:

SUBJECT: Certificate of Need Legislation

I am sure that you have seen by now the summary of arguments from the Montana Hospital Association which would support the sunseting of certificate of need in Montana. At the moment we are the only state in the Rocky Mountain region which continues certificate of need. CON came out of a federal legislative process in the mid-1970's to control health care costs through the regulatory process. There are many studies which indicate that this simply hasn't worked. Today, competition appears to be more effective than regulation in controlling cost and as a result Congress suspended all funding for CON and CON related agencies in September 1986.

I am aware that some provider groups want to retain CON and that at least one bill, SB217, would remove the sunset provision so that CON would continue in perpetuity with hospitals locked inside the statute. I think this is wrong. Instead, I would support the bill which is being introduced or, by now, has probably been introduced, by Senator Bob Williams which would exempt hospitals from certificate of need. I feel that hospitals should not have to pay for a system which extends to what amounts to health care franchises to non-hospital providers. The Williams bill would require a hospital to obtain a CON if it wanted to provide or extend services in swing beds, long-term care (including personal care), inpatient psychiatric facilities, inpatient chemical dependence facilities, inpatient rehabilitation facilities, home health services or hospice services. In the twelve states which have sunsetted CON,

Senator Jerry Noble
February 7, 1989
Page 2

the growth areas have been in long-term care beds, psychiatric beds and chemical dependency beds. The Williams bill would still require CON for these services.

Although the Montana Hospital Association, and Columbus Hospital management, would support full sunseting of CON, we see the Williams bill as a reasonable compromise. It satisfies the concerns of all aspects of the provider community, leaving hospitals out and others in. We recognize that all hospitals in Montana do not agree with the position of the Montana Hospital Association, but the vast majority - at least three fourths - do. Few issues find total unanimity but on this one I believe I speak not only for us but for the vast majority of Montana hospitals when I say that given the tightening financial restraints on hospitals, the responsible behavior of hospital trustees and administrative staffs in the competitive marketplace in which we find ourselves, certificate of need is no longer necessary. I believe Montana hospitals will work responsibly without it and save the excessive costs of regulation associated with the current legislation in which as much as twenty five percent or more of the costs of applying for certificate of need are paid in attorney fees.

Thank you for the opportunity to comment on this legislation. If you would like to discuss it further with me, please contact me.

Sincerely,



William C. Downer, Jr.
President

WJD:hv

bcc: Mr. James Ahrens

(same letter to: Senator Gene Thayer
Senator Mike Walker
Senator Darryl Meyer,



Carbon County Memorial Hospital
& Nursing Home

P.O. Box 590
Red Lodge, MT 59068
(406)446-2345

Dear Legislator:

Carbon County Memorial Hospital and Nursing Home
opposes "Certificate of Need" in its entirety. We are also
in opposition to Senate Bill 217.

We do however, support Senate Bill 340 and would
encourage your support for passage of this bill.

We thank you for your time and for your commitment to
Montana.

Sincerely,

Mark L. Teckmeyer
Administrator

Clark Fork Valley Hospital

Post Office Box 768 • Kruger Road
Plains, Montana 59859 • (406) 826-3601



February 10, 1989

Jim Ahrens
Montana Hospital Association
P.O. Box 5119
Helena, MT 59601

Dear Jim:

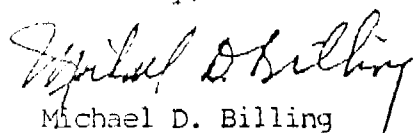
Your secretary called yesterday requesting a letter in regards to Certificate of Need. First, I am against Certificate of Need in any form in this state. I realize that if we can get hospitals excluded and not a nursing home then we have made a gain perhaps, but I would much prefer having Certificate of Need eradicated.

In 1978 we tried diligently to get a 13 bed Nursing Home constructed and it was denied through the CON process, largely due to opposition to the project from competitors in Hot Springs. The cost of the project at that time was about \$120,000. Two years later we battled again with the forces and got approval for a 12 bed Nursing Home and constructed it during the year of 1980. It was open December 22, 1988. The total cost of construction on this smaller unit just a few years later was \$315,000. The point of course is that CON serves to drive the cost of construction up through time delay of the construction.

The other factor I see with CON in terms of our Nursing Home business is that the Nursing Home for instance in Hot Springs, Montana has a franchise and basically keeps us from building more Nursing Homes here. We almost constantly have a waiting list for people to come into our Nursing Home but due to the fact that we can't build more beds, which are needed, they must wait several weeks, or months to be admitted. They in fact will not go to Hot Springs because of its location and the services provided there. This is not to say that Hot Springs is a bad Nursing Home, for it really isn't, it's a pretty nice Nursing Home but it's located at a distant place where easy access to higher level health care services are not available.

The franchising effect of CON for older established Nursing Homes in Montana keeps the population who needs nursing home care from having care delivered in a modern setting. If CON was removed, I believe there would be nicer nursing home facilities available for the population and they would be located where they are most needed. This may all sound kind of funny because that's what CON may have been trying to achieve in the first place.

Sincerely,


Michael D. Billing
Executive Director



HOLLIS K. LEFEVER, M.D. FAAFP
LEWISTOWN, MT. 59457

DIPLOMATE AMERICAN BOARD
OF FAMILY PRACTICE

SENATE HEALTH & WELFARE
EXHIBIT NO. 8
DATE 2-10-89
BILL NO. SB217-340

Senators:

The certificate of need law 50-5-301, part 3, may be referred to as the State Franchise Bill, it was initially conceived to prevent unnecessary duplication of health care facilities, equipment and services that would result in extra cost to the health care recipients or the public through the expenditures of tax funds. The law has failed miserably to accomplish these goals and is no longer a necessary obstacle in the provision of health care in Montana. Indeed, the bill has never proved a cost saving measure and has cost the health care industry in Montana literally millions of dollars as well as the tax payers of Montana who are spending almost a quarter of a million dollars annually just to keep the State Department funded to oversee the certificate of need law. Only a third of the expense for the operation of the State Department responsible for the enforcement of this law is paid by health care providers. Even so, the amount paid by health care providers is a considerable burden to each health care facility attempting to improve it's ability to provide current state-of-the-art health care. The bill has been demonstrated to invite bias, excessive socioeconomic & political pressures, and to not only hamper the effort at facilities to provide needed services but to saddle the patients in our facilities with tremendous extra cost involved in funding the certificate of need process. Indeed, Montana is remiss in not having repealed this law much sooner. We are the only Rocky Mountain State to still have such a law in the books. Our neighbors Arizona, Colorado, Idaho, New Mexico, Utah, and Wyoming do not have such a law. California, Texas, Kansas, and Minnesota have rejected this type of legislation. The law includes, among other undesirable elements, a restraint of trade. The Federal Trade Commission reported that CON grants a franchise and inhibits competition and thereby increases health care costs. In September of 1986, Congress suspended all funding for CON and CON related agencies because it did not reduce cost. The Federal Government, through the Medicare Program does not pay hospitals according to the money they spend. Hospitals are reimbursed according to the diagnoses of the diseases they care for. Excessive expenditures to care for those diseases would only jeopardize the hospitals financial stability. No additional federal reimbursement would be received because the hospital expended unnecessary funds to provide facilities, services, or equipment. The DRG law ended that. Indeed the only rational way to justify expenditures in the 1989 scene of health care and all the demands that are made for cost containment and quality care, is to allow individual facilities to make capital investment decisions based upon community needs, availability of the service in the area, the volume of the potential demand for the service, and the ability of the health care consumer to pay for the service so that the facility

PAGE TWO.

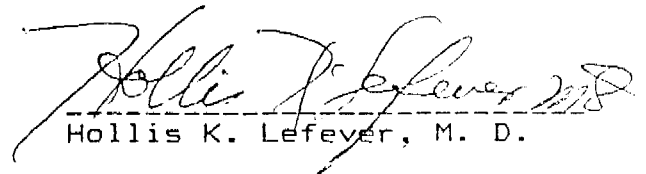
will be able financially to continue to provide the service with the reimbursement it can obtain for it. Having considered these factors and made an intelligent decision, health care facilities administrations and boards should not be hampered by second guessing at a State level, particularly when that second guess, namely the CON review process, is so costly and time consuming & comparatively uniformed about local needs.

What are these costs? First of all, there is a major cost simply to file the application with the State to obtain a certificate of need. Second, there are large costs in obtaining legal and financial feasibility studies to accompany the application, and third, there are great costs in time and services of institutional personnel to gather all of the data and information needed to submit a CON application. And, let's don't forget that while all of this is going on (a process which has been proven to take months and even years in Montana) that service is being denied to the patient's in the area and the revenue from that service is being denied the facility which is trying to survive in this age of economic realities in the health care field. Twelve States have eliminated this type of legislation so that the health care industry was deregulated. Those areas have not seen excessive growth in the provision of services for acute care.

I have been watching the needs and the attempts to meet these needs in Montana since 1958. I have been in the private practice of medicine. I have tried to deal with these problems as a physician admitting patients to acute care hospitals in Glendive and in Lewistown. I have tried to provide services while serving as President of the Medical Staff and Boards of these hospitals, I have watched the health care needs in the State as past president of the Montana Medical Association, and I have heard the certificate of need presentations as I served on the area health council. I have watched the frustration and humiliation of hospital administrators presenting applications where the cost of the applications far exceeded the cost of providing the service. I have watched patients in communities do without needed services either because of denial under the certificate of need law, or the fear of denial, or the fear of the expense in attempting to obtain a franchise to provide a much needed facility, service or equipment. The small hospitals in which I work and the smaller hospitals than that, don't have tens of thousands and hundreds of thousands of dollars to spend on legal fees, surveys and application fees. They have a hard enough time scraping together the dollars to buy a piece of X-ray equipment or to set up a surgery suite or to create a certain type of acute care bed that is critically needed. I well remember our committee hearing the applications of a facility where twice as much money was spent obtaining a certificate need as was needed to move an X-ray unit from a Physician's office into the hospital. This was not only absurd, it was unconscionable in this day and age of limited funds and almost unlimited health care needs for our citizens. Now that

PAGE THREE.

the certificate of need is determined by the State Department of Health & Environmental Science, some of the steps have been eliminated but it has not reduced the cost, uncertainty, and erroneous decisions that could be avoided if the CON law were simply allowed to die at this time. We have seen the State approve CON's for facilities when those of us in the health care industry watched with dismay and could not believe that they could have been approved, and at the same time we have watched the State deny CON's only to have them overturned in court. How long will you, our respected Legislators, perpetuate this folly? If indeed you feel that long term care facilities and psychiatric and drug abuse services would proliferate without the law, then accept Senator William's compromise bill, Senate Bill 340. But, please remove the hobbles from the feet of those of us who are trying to provide health care services to the acutely ill in Montana. Eliminate certificate of need restrictions for acute care facilities and providers in our State.


Hollis K. Lefever, M. D.

Cardiovascular &
Thoracic Surgery

TIMOTHY A. DERNBACH, M.D., F.A.C.S.
SHAF G. HUBBARD, M.D., F.A.C.S.
DAVID L. CORROD, JR., M.D.

SENATE COMMITTEE ON HEALTH CARE
DNRBH NO. #11
DATE 2-10-89
BILL NOS. SB 340 & SB 517

TESTIMONY OF DR. TIMOTHY A. DERNBACH BEFORE THE SENATE COMMITTEE

FEBRUARY 10, 1989

CERTIFICATE OF NEED LEGISLATION

Mr. Chairman and Members of the Committee, I am Dr. Timothy A. Dernbach. I am a cardiovascular surgeon and have practiced in Billings for the past ten years. I am also a native of Lewistown, Montana, and received my undergraduate training at Carroll College in Helena.

I am testifying to support Senator Williams' Bill, Senate Bill 340, and would strongly oppose Senator Halligan's Bill, Bill 217.

The purpose and intent of the Certificate of Need law has been to prevent unnecessary expenditure of funds for medical facilities which are unneeded and to prevent duplication of services in order to provide more cost effective medicine to the population. I think that the CON laws have been largely ineffective in obtaining their objectives and, in fact, have increased the cost of medical care in most states in which they have been implemented. Because of this, there are very few remaining states that utilize Certificate of Need laws.

With the recent implementation of DRG's (Diagnosis Related Groups), hospitals are reimbursed a fixed amount of money based on a specific diagnosis which the patient has. It is the responsibility of the hospital to supply quality service to the patient within the cost confines of the DRG. Because of this, it is fiscally unsound for any hospital to install a health service which it cannot pay for and which is not cost effective. I think that it is extremely difficult for a Hearing Board or Committee in Helena, Montana, to make a knowledgeable decision about the needs of a community hospital 200 miles away. It is not infrequent for the expense of obtaining a Certificate of Need to exceed the cost of installing the facility requested. I think it is essential that smaller hospitals, which we have throughout Montana, be allowed to make their own decisions with regard to the services they think they both need and can produce cost effectively. Every hospital has its own governing board which is responsible for its fiscal decisions and also has its own medical staff which should be capable of determining the medical needs in their area.

The Certificate of Need process has virtually perpetuated monopolies instead of allowing competition which, according to the American way, has guaranteed quality care and competitive pricing.

I feel strongly that the time has come to allow hospitals to govern their own destiny. I think that the hospitals not only are capable of making decisions with regard to the services they offer, but are in a much better position to determine what they can and cannot afford. Please allow our local hospitals, hospital boards, and local medical staffs to decide the needs and/or services for their own communities. I would urge you to support Senator Williams' Bill, Senate Bill 340.



**Montana
Deaconess**

Medical Center

1101 Twenty Sixth Street South
Great Falls, Montana 59405-5193
406 761-1200

SENATE HEALTH & WELFARE
EXHIBIT NO. 12 A
DATE 2-10-89
BILL NOS 217-340

February 10, 1989

Chairman, Tom Hager, and Members of the Public Health, Welfare, and Safety Committee:

I am Ray Gibbons, representing Montana Deaconess Medical Center in Great Falls, speaking in support of SB 340.

As I have stated previously, we feel that the CON law should be allowed to sunset; however, we do feel that SB 340 would be a reasonable compromise.

This bill addresses the concerns of the various health care provider groups; and, although unanimity on any issue is difficult, we feel that we can support this bill.

We continue to feel that the current and future of health care in Montana, as well as the nation, has become a resource restricted business which necessitates sound business planning. The resources that are and will continue to be restricted are human, physical, equipment, and financial. The resource allocation process is currently being performed by the management of health care facilities. Therefore, we feel that the legislature demonstrated foresight in 1987 by sunseting the CON law in 1989; however, if this is not possible we do support SB 340 which does include hospitals in the CON process only for the provision of ambulatory surgical care, home health care, long term care, inpatient mental health care, inpatient chemical dependency treatment, inpatient physical rehabilitation, and personal care. This bill does allow the competitive forces to determine the needs of other programs and services provided by hospitals and allows their business planning process.



**Montana
Deaconess**

Medical Center

1101 Twenty Sixth Street South
Great Falls, Montana 59405-5193
406 761-1200

SENATE HEALTH & WELFARE

EXHIBIT NO. 126

DATE 2-10-89

BILL NO. SB 217 1340

February 10, 1989

Chairman, Tom Hager, and Members of the Public Health,
Welfare and Safety Committee:

I am Ray Gibbons, VP for Technical Services, representing Montana Deaconess Medical Center in Great Falls, speaking in opposition to Senate Bill #217 which would remove the sunset provisions relating to the CON laws.

The health planning process and CON process had its origins in the early 1970's and has continued through the 1980's. We supported the original intent which was public/patient involvement in the major planning efforts by healthcare providers in their areas. We demonstrated this support of the process by having our staff involved in committees throughout this time period with one significant one being Sharon Dieziger, who I am sure you all know. However, the health care system has changed dramatically since the 1970's which was recognized by this very committee in 1987 when they passed the sunset provision for the CON law. We applauded the sunset provision at that time and continue to feel that the CON has become antiquated in the present competitive health care environment.

The environment, even since 1987, has changed dramatically with the shrinking reimbursement levels and the absolute necessity to be sure that each new venture have a sound business plan which incorporates financial, resource (i.e. human and equipment), and facility planning. The Montana Deaconess standard format for review of new projects is attached and identifies the depth of review currently provided by hospital providers. The federal government and other accrediting agencies for health care facilities have all changed their focus since 1987 into the quality assessment arenas and not into the arenas of trying to control programs or equipment initiated by hospitals.

Hospitals are usually major employers in their communities and the management of these facilities take their roles seriously in providing only programs that have solid business plans for their stake holders. We feel that the changes in the late 80's will continue into the 90's in the health care and hospital industry; and these changes will continue to demonstrate the foresight of this committee in 1987 of sunseting the CON law. Therefore, we feel that Senate Bill #217 would be a step backward for the hospital industry and the citizens of Montana.

Attachment: MDMC Standard Format for Program Analysis

BUSINESS PLAN FORMAT

- I. PROJECT DESCRIPTION - This is a narrative summary of what the project entails.
- II. PROJECT INVESTMENT (Expenditures) - Detailed identification of capital and other expenditures.
- III. METHOD OF FINANCING PROJECT - This would include the options, as well as a recommendation.
- IV. PATIENT VOLUMES AND PROFILES - This would identify the volumes projected by the various providers within the facility and the basis for those projections, the capacity of the equipment, and physical spaces. Addresses competition, the key physicians involved, and the patient payor mix that would be expected.
- V. PATIENT CHARGES AND THIRD PARTY COVERAGE - Identifies expected charges and investigation as to third party coverage.
- VI. AVAILABILITY AND PROJECT TIME TABLE - This would be a detailed identification of the components of the project, for example, equipment time tables, renovation required, staff training, supplies, assistance, protocols, marketing down to a recommended implementation date.
- VII. PRO-FORMA - Which would be the detailed volume, revenue, expense, net cash flow, net P & L, pay back, return on investment, including options and a final recommendation.



Wheatland Memorial Hospital
and Nursing Home

530 - 3rd Street N.W.
Box 287
Harlowton, Montana 59036

SENATE HEALTH & WELFARE

EXHIBIT NO. 1 #13

DATE 2-10-89

BILL NO. SB 217 + 340

TESTIMONY OF JOHN H. JOHNSON BEFORE THE SENATE COMMITTEE

Dated: February 10, 1989

Titled: Certification of Need Legislation

Mr. Chairman, Members of the Committee, for the record my name is John H. Johnson, Administrator of Wheatland Memorial Hospital and Nursing Home in Harlowton, Montana.

I am in support of the elimination of the Certificate Of Need law as it relates to hospitals and as it is somewhat contained in Senator Williams' bill. I am opposed to Senate Bill 217.

Senator Williams' bill is a step in the right direction. Certificate of Need law does not give hospitals the flexibility they need to adapt to the changes in health care.

Lets look at how Certificate Of Need law affects a small rural hospital, like Wheatland Memorial. Lets assume that a hospital has been offering mammography as a service for a number of years. It now wants ultrasound. Since ultrasound is technically considered a new service for that hospital, it must go through the CON process. Relatively speaking, ultrasound is not expensive technology. But look at how the costs of that equipment increase when the costs of the CON process are included.

First of all, there is the application to prepare. No easy matter. Need has to be determined, financial feasibility has to be shown. For a small hospital, coming up with six to eight thousand dollars to pay a consultant is not always possible. So the administrator prepares the CON. This administrator also has to function as the marketing department, the personnel department, and fiscal services. The administrator then submits the application to the State Department of Health for a fee, of course. So far so good, until some other provider challenges the application. Then the administrator has no choice; he or she must retain legal counsel and go through the hearing process. More fees. This entire process may take several months, which means several months of lost revenue to the hospital that needs the revenue now.

Large hospitals go through the same process. They pay the same fees, or in most cases, more. But the impact is far less devastating. For one thing, a small hospital does not have the volume of privately insured or self-pay patients that a large hospital does. These patients would ultimately pay the costs of the new development. The small rural hospital depends primarily on Medicare and Medicaid. For example, we hear stories all around the country about the high percentage of Medicare payer mix in the rural hospital settings. At this point in time, Wheatland Memorial Hospital's payer mix for Medicare has been over 80%. With Medicare and Medicaid both capping reimbursement, this limits the hospitals funding for new development. Ironically though, Medicare and Medicaid are pushing small rural hospitals, like Wheatland Memorial, to diversify and offer more cost effective alternatives to acute care.

But the expense and the time involved in the CON process prevents small hospitals from responding to these needs. So in effect, our hands are tied.

Deregulating hospitals will reward the creative administrator. Creativity is necessary for a hospitals survival in todays environment. Yes we are victims of the Medicare and Medicaid systems, but the CON law removes the one strategy we do have to counteract the reimbursement system - diversification.

In the past five years, Wheatland Memorial Hospital and Nursing Home has made every attempt to position itself on the leading edge of the reimbursement issues. As we have continued to go more outpatient services, Medicare and Medicaid have continued to reduce our reimbursement. As small rural hospitals, we are now fighting for survival on a daily basis. Its bad enough we have to continually fight Medicare, our primary hospital payer on a national basis, are we also going to have to fight the State of Montana in order to stay alive?

Mr. Chairman, members of the Committee, I am in strong support of the elimination of the Certification of Need law in the state of Montana.

Saint Vincent Hospital and Health Center

SAINT VINCENT HOSPITAL AND HEALTH CENTER
TESTIMONY OF JAMES T. PAQUETTE BEFORE
THE SENATE PUBLIC HEALTH COMMITTEE
FEBRUARY 10, 1989
CERTIFICATE OF NEED LEGISLATION

Mr. Chairman, members of the Committee, my name is James T. Paquette and I serve as President and Chief Executive Officer of Saint Vincent Hospital and Health Center, a 280-bed general acute care hospital in Billings, Montana. We have consistently taken a position against Certificate of Need for hospitals since the changes in Medicare Medicaid reimbursement went into effect in the mid 80's.

We are in support of elimination of Certificate of Need law as it relates to hospital construction and as it is embodied in Senator Williams' bill. We are also opposed to Senate Bill 217, because it represents a giant step backwards.

Why should hospitals be exempt from Certificate of Need law?

Decades ago, Certificate of Need legislation was intended to function as a cost-containment device. When it was first enacted during the early 70's, there was little incentive for hospitals to control their costs. Medicare and Medicaid reimbursed on a cost plus basis, so the more they spent, the more they were reimbursed. In this new era, decisions to enter into new services or purchase capital are based upon: 1) demand; 2) ability to command a price in the market to cover costs and provide margin for capital; 3) ability to produce quality health care. Certificate of Need law is not necessary to control unwarranted growth.

Will there be a dramatic increase in hospital services and beds with the adoption of Senate Bill 340.

No. Senator Williams' bill allows long-term care beds, psychiatric, mental health, substance abuse, and rehab programs to remain under the protection of Certificate of Need law. Any provider who wants to get into these programs must go through the CON process. Hospital services would be the only services deregulated.

Contrary to some of the stories you have heard, deregulation does not promote overbedding. In Wyoming for example, deregulation was initiated in May, 1987. At that time, 600 long-term care beds had already been approved under CON law. Since then, approximately 400 of those beds have either been completed or are still under construction. No other capital activity is anticipated for several years. Granted,

Wyoming's economy doesn't allow for much activity. But, Wyoming's economy more closely parallels Montana than does Arizona and Utah. These two states, of course, are cited by the proponents of Certificate of Need law as examples where deregulation only fuels unnecessary construction.

Will the passage of Senate Bill 340 encourage large hospitals to overtake small rural facilities?

Absolutely not. Consider the hospitals across the state as a system. Since we are largely a rural state, the strength of that system lies in the smaller hospitals. We depend on quality health care in the rural areas. Currently, the larger urban hospitals conduct educational programs and provide services for rural facilities to enhance that quality. A specific example of this exists in our service area relating to Big Timber. Saint Vincent Hospital and Health Center assisted the local physician and hospital administration in developing a health care package for the Boulder Mining Company tentatively scheduled to open in 1990. The package, which would provide occupational health and medical services through the local medical community with comprehensive back-up, was positively received by company officials. Although the package may ultimately generate referrals to Saint Vincent Hospital and Deaconess Medical Center or others in the larger urban areas, the principal beneficiary is Big Timber, its people, its hospital and its physicians.

We, at Saint Vincent Hospital and Health Center, can personally attest to the time, cost and ineffectiveness of the Certificate of Need law. We are currently undergoing a process that has cost us over \$250,000 to date and countless hours on the part of management that could be much better spent on quality of care issues or passing on savings to consumers.

In summary, we oppose the Senate Bill 217 which allows for the permanent reinstatement of the current Certificate of Need law and support the Williams compromise bill for the following reasons:

1. There is no proof that CON legislation reduces cost to the consumer.
2. There is supporting documentation that CON legislation raises costs of operation to hospitals.
3. CON legislation is a clear restraint of trade and hinders the opportunity for hospitals to function in the free marketplace.

Mr. Chairman and Members of the Committee:

I am Dr. David Klein, a general surgeon practicing in Billings, where I have lived for 23 years. I am also a native of Montana, having grown up in Helena. I have been very much involved with improvement of health care in this state over the years, both through my membership in the American College of Surgeons and also through my involvement with the delivery of emergency medical services and transport systems in eastern Montana. I have also been involved with federally mandated health care planning and the Montana State Certificate of Need law since health planning started many years ago. I am in support of the elimination of Certificate of Need law as it relates to hospitals, and I am opposed to Senate Bill 217.

I am distressed that so many legislators are attracted to the continued regulation of health care facilities through the Certificate of Need law. While I share their goals, as we all do, of improving access to health care at an affordable price for all of our citizens, the unfortunate truth is that the Certificate of Need law is having just the opposite effect from that desired by its advocates. The federal government has completely abandoned support for health care planning as a method of keeping health costs down, recognizing that it has not achieved this goal, and has in fact increased health care costs. There are no longer federal sanctions for violation of the Certificate of Need law, and only a very few states continue to rely on CON laws. As you are surely aware, many studies relating to the impact of Certificate of Need laws on health care costs have arrived at the same conclusion, that these laws do indeed increase the cost of health care in the states where they are in effect. In order to comply with the Certificate of Need laws health care facilities are burdened by inordinate costs, all of which must, of course, pass through to patients. The Federal Trade Commission has been actively lobbying for the abolition of all remaining Certificate of Need laws based on their perception that they are anticompetitive and do in fact lead to the perpetuation of unfair monopolies. Monopolies do not work any better in the health care industry than in any other industry, and monopolies which are mandated and protected by law are the most anticompetitive of all. In fact, the health care providers who most strongly favor CON legislation are those whose monopoly is protected by it.

In addition, a highly regarded study reported last spring has demonstrated that hospital mortality rates among Medicare patients were significantly higher in states with stringent Certificate of Need requirements than in less regulated states. Thus, Certificate of Need laws increase health care costs through the perpetuation of monopolies and through the tremendous costs of compliance with the law, and they very likely lead to a decrease in quality of care. Like so much populist legislation, these laws are well intentioned, but have the opposite effect from that desired. Medicare-Medicaid reimbursement policies are more effective in controlling hospital costs than any government regulation.

If the smaller health care facilities in Montana are afraid that the larger hospitals will overrun them if the Certificate of Need legislation is allowed to sunset, I would suggest that they have a great deal more to fear from the Medicare reimbursement rates for rural hospitals than they do from the larger hospitals in their area. Those of us who have been involved with emergency medical transport and outreach programs in smaller outlying areas are acutely aware of the tremendous importance of smaller rural hospitals and the need for continuing education and upgrading of skills by health care providers in these smaller rural communities. It is distinctly in the interest of large hospitals and urban medical communities to strengthen the health care delivery systems in rural areas, and it is certainly not in the larger hospitals' best interest to try to take them over. The urban medical community and hospitals can perform their specialized functions much better and more efficiently if the smaller rural hospitals are strengthened, not if they are weakened. I emphasize to you once again that while I share the goals of the Certificate of Need advocates, these goals can much better be achieved through free competitive health care pricing and delivery of services, than through the flawed and counter-productive Certificate of Need laws.

(This sheet to be used by those testifying on a bill.)

SENATE HEALTH & WELFARE

NAME: Pat Melby

EXPIRATION NO. # 16

DATE 2-10-89

DATE: 2/10/89

ADDRESS: P.O. Box 1144

BILL NO. SB 217-340

PHONE: 442-7450

REPRESENTING WHOM? Rimrock Foundation

APPEARING ON WHICH PROPOSAL: _____

DO YOU: SUPPORT? SB 217 AMEND? _____ OPPOSE? SB 340

COMMENT: There is no rational basis to discriminate between some hospital services and other health care services - SB 340 raises serious questions under both the US & Montana Constitution of the denial of equal protection between health care providers.

If the Legislature wishes to exempt certain health care services it should specifically list those services to be exempted!

I am the attorney for Broadwater Health Center in Townsend. It supports SB 217 and opposes SB 340

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.



1988-1989
MONTANA STATE LEGISLATIVE COMMITTEE

SENATE HEALTH & WELFARE

EXHIBIT NO. 17

DATE 2-10-89

BILL NO. SB 217-340

CHAIRMAN
Mrs. Molly L. Munro
4022 6th Avenue South
Great Falls, MT 59405
(406) 727-5604

VICE CHAIRMAN
Mr. Fred Patten
1700 Knight
Helena, MT 59601
(406) 443-3696

SECRETARY
Mr. John C. Bower
1405 West Story Street
Bozeman, MT 59715
(406) 587-7535

February 10, 1989

TO: Senate Public Health, Welfare, and Safety Committee

FROM: Fred Patten, American Association of Retired Persons

RE: Senate Bill No. 340: "AN ACT TO REVISE AND CONTINUE CERTIFICATE OF NEED LAWS, TO EXEMPT HOSPITALS FROM CERTIFICATE OF NEED REQUIREMENTS."

The American Association of Retired Persons State Legislative Committee does not support Senate Bill No. 340 for all the reasons we used to support Senate Bill No. 217. We use these reasons to object to Senate Bill No. 340. We feel this would not slow the rate of Health Care costs. We feel that by exempting hospitals from this law there would be duplication of expensive equipment and facilities. There would no longer be any rational planning of health care facilities. Hospitals would not be required to have reason for excess capacities. There would be no sharing of medical technology or no rationale for planning of a new health care facility.

We urge you to vote DO NOT PASS on this bill.

NAME: Sandra Erickson DATE: 2-10-89

ADDRESS: 401 3rd Ave North Great Falls MN

PHONE: 406 727-2512

REPRESENTING WHOM? Providence Chemical dependency treatment
Center - Cascade, Pondera, Glacier Counties

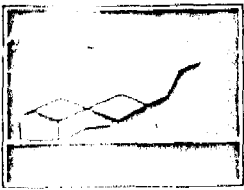
APPEARING ON WHICH PROPOSAL: SB 217

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENT: _____

see attached

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.



St. John's Lutheran Home

3940 Rimrock Road • Billings, MT 59102 • (406) 656-2710

SENATE HEALTH CARE
EXHIBIT NO. 20
DATE 2-10-89
BILL NO. SB 217-370

TO: YELLOWSTONE COUNTY LEGISLATORS

FROM: KRISTIN RAPACZ, ADMINISTRATOR
ST. JOHN'S LUTHERAN HOME

DATE: FEBRUARY 7, 1989

SUBJECT: SENATE BILL #217

The purpose of this letter is to notify you of our deep concern regarding the sunseting of the CON process in Montana, and to strongly encourage you to see that the CON process is preserved.

THE CON PROCESS HAS HAD A POSITIVE IMPACT ON MONTANA:

1. The CON process in Montana has prevented unnecessary duplication of services. It has prevented the "for profit" take over of a wide range of services including nursing homes, chemical dependency treatment centers and psychiatric treatment centers.
2. The CON process in Montana has provided the careful planning that is necessary to ensure high occupancy rates and high utilization rates of nursing homes and other services. High utilization rates are necessary to keep costs down and provide high quality services.

THE SUNSETTING OF THE CON PROCESS IN MONTANA WOULD HAVE A NEGATIVE IMPACT ON MONTANA:

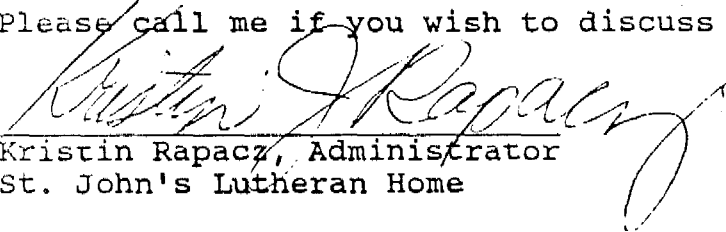
1. The sunseting of the CON process in Montana would open the door for overbuilding and the unnecessary duplication of services.
2. The sunseting of the CON process in Montana would bring in a flux of for-profit providers and would upset the balance of for-profit and not-for-profit providers that currently exist in this state.
3. The sunseting of the CON process in Montana would permit overbuilding that would result in lower occupancy and utilization rates which would then lead to higher costs and lower quality of care and services.

Page 2
Cont.

Normal market forces will not adequately regulate the supply and demand for services in the absence of the CON process. In the states of Utah, Arizona, Kansas and California, where the CON process has sunsetted, the negative forces mentioned above have occurred.

Please see that the CON process in Montana is preserved so that high quality services can continue to be provided at reasonable costs.

Please call me if you wish to discuss this further.



Kristin Rapacz, Administrator
St. John's Lutheran Home

KR:pk



Montana Association of Homes for the Aging

P.O. Box 5774 • Helena, MT 59604 • (406) 443-1185

SENATE HEALTH & WELFARE

EXHIBIT NO. #21

DATE 2-10-89

BILL NO. SB 217-340

TO: Members of the Senate Public Health Committee
FROM: Jean Johnson, Executive Director
Montana Association of Homes for the Aging
DATE: February 10, 1989
RE: SB 217 and SB 340

Mister Chairman, members of the committee, I am here on behalf of the Montana Association of Homes for the Aging to support SB 217. The Montana Association of Homes for the Aging represents twenty-two nonprofit retirement and nursing homes.

Because our homes are nonprofit and sponsored by religious, fraternal, and governmental means, our focus is not the "bottom line of the ledger" but rather, successfully meeting the needs of our elderly residents. For that reason, we are concerned that without a certificate of need requirement, for-profit providers may contribute to an "over-bedding" situation in Montana. "Over-bedding" can result in lower occupancy and utilization rates which in turn can lead to higher costs and lower quality care and services.

The Montana Association of Homes for the Aging wishes to go on record as opposing SB 340 which exempts hospitals from the certificate of need requirement. The reason for our opposition is that we fail to see a compelling need for the exemption.

NAME: R. Joseph Rude DATE 2-10-89 BILL NO SB 217-340 DATE: 2.10.89

ADDRESS: 4619 Rimrock Rd. Billings MT

PHONE: 259-9034

REPRESENTING WHOM? Health & Marketing West

APPEARING ON WHICH PROPOSAL: SB 217

DO YOU: SUPPORT? ☒ AMEND? ☐ OPPOSE? ☐

COMMENT: In a delicate economic environment
CON is essential to the survival of Health Care
facilities. CON avoids unnecessary duplication
maintains lower costs in health care and
helps maintain the quality of care.
In neighboring states the loss of CON
has contributed to the closure of small
rural hospitals.

SB 217 is preferred to 340 because
it has 1) no sunset

2) is broader in its coverage

3) provides better protection

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Community Hospital

Grant M. Winn, EXECUTIVE DIRECTOR

SENATE HEALTH & WELFARE

EXHIBIT NO. # 23

DATE 2-10-89

BILL NO. SB 217-340

Community Medical Center
2827 Fort Missoula Road
Missoula, Montana 59801
(406) 728-4100

February 10, 1989

Senate Public Health, Welfare and Safety Committee

Chairman Tom Hager
Tom Rasmussen
Matt Himsl
J.D. Lynch

Harry H. "Doc" McLane
Bill Norman
Bob Pipinich

Dear Senators:

I support SB 340 which removes hospitals from the Certificate of Need Law (CON). SB 340 maintains CON for the services that many providers believe should remain in the process.

I support SB 340 for the following reasons:

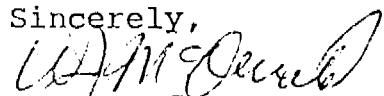
- * Since 1984 hospitals have been reimbursed on a prospective basis by Medicare and by Medicaid. This payment system does not allow hospitals to pass on extra costs to patients.
- * Hospitals are in an increasingly competitive environment that requires sound business decisions, CON requirements are superfluous to this process.
- * CON is itself contributing to health care costs. For example, Community Medical Center is currently building a state of the art rehabilitation center that will replace inadequate beds currently in use. The service is running at maximum capacity and the new facility is necessary to meet the current demand. The CON application was \$28,000 and the estimated cost of preparing the CON report was \$50,000. Community has spent thousands over the years on CON applications. None of Community's applications have been denied.

Page Two

Although I question the need for any CON law given the future cost constraints anticipated in health care, I believe SB 340 provides an acceptable alternative.

Thank you.

Sincerely,

A handwritten signature in dark ink, appearing to read 'WJ McDonald', written in a cursive style.

WILLIAM J. MCDONALD
Asst. Vice-President
Corporate Services

WJM:edn

SENATE HEALTH & WELFARE
EXHIBIT NO # 24
DATE 2-10-89
BILL NO SB 217-340

TESTIMONY OF JACK TENGE BEFORE
THE SENATE COMMITTEE
February 10, 1989
CERTIFICATE OF NEED LEGISLATION

Mr. Chairman and members of the committee, my name is John aka as Jack Tenge. I am a seniors' advocate and a member of the Golden Care Plus board of Saint Vincent Hospital.

I am here in support of the elimination of Certificate of Need law as it relates to hospitals and is incorporated in Senator Williams' bill No. 340. I am opposed to Senate Bill No. 217.

In my judgement, a Certificate of Need law for hospitals is no longer needed and if one is enacted, hospitals should be exempt therefrom. Medicare and Medicaid hospital patient costs are now reimbursed on the principal diagnosis made by the physician under a code number called a Diagnostic Related Group, commonly referred to as a DRG. Medicare and Medicaid pay a set fee for each DRG, regardless of the length of the patient's stay, the complications he or she may experience or the hospital's actual costs. In short, there is a "cap" on the reimbursement a hospital receives for patient care, thereby creating a real incentive for management to control its costs. Any costs above the amount allowed under the DRG is absorbed by the hospital.

The funding of patient care in a nursing home however, is quite different, and for the present at least, I believe a Certificate of Need law makes sense.

The quality of our lives is important to all of us. It is especially important to those of us in our sunset years when anxiety about our ability to care and provide for ourselves is frequently on our minds.

All of us want our golden years to be happy, enriching and free of care or worry. Many of us however, will not be permitted to enjoy them in the freedom, comfort, security and serenity of our own homes, in familiar surroundings and amid the loving care of family members. Instead, we may be confined to a nursing home where the quality of our care for these "golden years" becomes the responsibility of the nursing home staff. I am a frequent visitor in nursing homes and am constantly amazed at the tender and compassionate care given the residents, as well as the efforts made to provide a cheerful and interesting atmosphere. It is nevertheless not the same as "being home", but as someone remarked, "growing old is not for sissies".

Living in a nursing home is also expensive. When an elderly

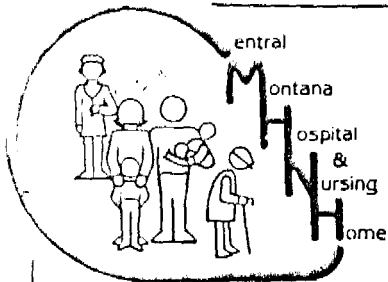
citizen's savings are gone and the family is no longer able to pay, the nursing home turns to Medicaid, which then picks up the tab in full. Surveys report that at least 50% of the residents in Montana nursing homes are destitute and completely dependent upon Medicaid to pay for their care. The present method under which Medicaid reimburses the home is on the basis of the number of beds it has, as related to the number of beds statewide, with some adjustment for the cost of labor and the acuity level of patients. This may be the best that can be done, but it has its shortcomings in that it provides no incentive for management to reduce the costs to the resident. On the other hand, it enables management to maximize its revenue by controlling the number of beds statewide. To that extent, a Certificate of Need law providing review of additional nursing home facilities seems reasonable, but it does nothing to reduce the costs of patient care.

With more elderly each year, an average nursing home occupancy of about 91% statewide, and construction costs of \$25-30,000 per bed, new nursing home construction may be profitable. For hospitals, however, the figures are quite different. Their average occupancy rate in 1987 was under 50% and the cost of each acute care bed, I am informed, ranges from approximately \$65,000 upwards.

Therefore, because of the changes in the way Medicare and Medicaid now reimburse hospitals, the Certificate of Need law is no longer effective as a way to control a hospital's costs. I believe a far better way is to reduce government regulation to a minimum and encourage open competition, thereby giving management a real incentive to be creative in finding ways to reduce its costs and those for its patients.

The growing elderly will eventually require more Medicaid funding to cover the costs of their care and Medicaid may change the way it reimburses the nursing homes, just as it has changed the way it reimburses hospitals. When that happens, the Certificate of Need law will cease to be an effective strategy for a nursing home as well.

In summary, the Certificate of Need law seems to make sense for nursing homes right now, but it is no longer needed to control hospital costs. Competition and a less restrictive environment is a far more effective strategy. For the reasons stated, I am opposed to Senate Bill No. 217, but heartily endorse enactment of Senate Bill No. 340 proposed by Senator Williams, as it relates to hospitals.



408 Wendell Avenue • P.O. Box 580
Lewistown, Montana 59457-0580
Phone (406) 538-7711

February 6, 1989

Senator Bob Williams
Montana State Senator
Capitol Station
Helena, MT 59620

SENATE HEALTH & WELFARE
EXHIBIT NO. #25
DATE 2/10/89
BILL NO. SB-340

Dear Senator Williams:

I am responding to your request for information regarding the cost of the Certificate of Need application recently submitted to add 15 new beds to the Nursing Home. These costs are as follows:

Fee to State for filing	\$2,829
Consulting fees	3,500
Internal costs (time, copying, phone calls, etc.)	2,000

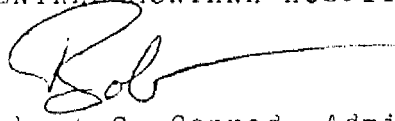
Estimated Cost	\$8,329
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This supposes no additional costs for legal fees and other consultant costs should our application be contested or denied, requiring an appeal or litigation. It also presumes there will be no increase in the cost of money due to the extra time required to go through the process (five - seven months). Any increase in interest rates would add significant costs to our project.

I hope this information is helpful.

Sincerely,

CENTRAL MONTANA HOSPITAL AND NURSING HOME


Robert G. Conrad, Administrator and
Chief Executive Officer

RGC/cje

STATEMENT IN SUPPORT OF SB 340

BY

SENATOR BOB WILLIAMS, DISTRICT 15

FEBRUARY 10, 1989

SENATE PUBLIC HEALTH COMMITTEE

SENATE HEALTH & WELFARE
EXHIBIT NO. 25
DATE 2/10/89
BILL NO. SB 340

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

MY NAME IS SENATOR BOB WILLIAMS. I AM PLEASED TO BE THE SPONSOR OF SB 340 ALONG WITH MORE THAN 50 OTHER SENATE AND HOUSE MEMBERS. SB 340 DOESN'T ELIMINATE CERTIFICATE OF NEED FOR ALL HEALTH CARE FACILITIES EVEN THOUGH THERE IS CONSIDERABLE SUPPORT TO DO SO.

SB 340 SIMPLY EXEMPTS HOSPITALS, WHICH IS A NEEDED COMPROMISE.

DOES THIS MEAN THAT A HOSPITAL COULD NOW OPEN A NURSING HOME WITHOUT GOING THROUGH THE CON PROCESS? THE ANSWER IS NO, AND LET ME TELL YOU WHY.

UNDER THIS BILL, AMBULATORY SURGICAL CENTERS, HOME HEALTH PROGRAMS, NURSING HOME BEDS, INPATIENT MENTAL HEALTH PROGRAMS, CHEMICAL DEPENDENCY TREATMENT PROGRAMS AND REHAB BEDS WILL STILL BE COVERED. ALL OTHER SERVICES, AS THEY RELATE TO HOSPITALS, ARE EXEMPT.

WHY SHOULD HOSPITALS BE EXEMPTED NOW?

CON LAW WAS FIRST ENACTED IN 1975 AS A COST-CONTROL DEVICE. AT THAT TIME MEDICARE AND MEDICAID WERE REIMBURSING HOSPITALS FOR THEIR COSTS. THERE WAS THEN LITTLE INCENTIVE FOR HOSPITALS TO CONTROL COSTS. AND WHY SHOULD THEY IF THEY COULD EXPECT TO BE REIMBURSED FOR ALL COSTS. THIS HAS NOW CHANGED.

TODAY, MEDICARE AND MEDICAID REIMBURSE ON A DRG-BASED SYSTEM. THE DRG SYSTEM ASSIGNS A "CODE NUMBER" TO EACH PATIENT, BASED ON THE PHYSICIAN'S DIAGNOSIS. MEDICARE AND MEDICAID PAY A FIXED AMOUNT PER DRG, REGARDLESS OF THE LENGTH OF STAY, COMPLICATIONS, ETC.

SO, IN EFFECT, MEDICARE AND MEDICAID HAVE REPLACED THE CON PROCESS AS THE COST-CONTROL DEVICE.

THE LEGISLATIVE AUDITOR'S REPORT RELEASED THE DAY BEFORE YESTERDAY IS THE BEST EVIDENCE AVAILABLE TO EXEMPT HOSPITALS, WHILE CONTINUING TO REVIEW THE PROJECTS OF OTHER HEALTH CARE FACILITIES.

ONE FINAL FACT SHOULD BE CLEARLY UNDERSTOOD: MONTANA IS THE ONLY ROCKY MOUNTAIN STATE WITH A CON LAW. STATES SUCH AS WYOMING, WHICH IS EVEN MORE RURAL THAN MONTANA ARE NOT EXPERIENCING ANY OF THE SO-CALLED FEARS YOU WILL HEAR TODAY.

FINALLY, I BELIEVE THIS LEGISLATION WILL NOT BE HARMFUL TO RURAL HOSPITALS. AS A FORMER BOARD MEMBER OF ONE OF THEM, I AM CERTAIN THAT THERE WILL BE MANY RURAL HOSPITALS WHO WILL SUPPORT THIS BILL.

THIS BILL IS A COMPROMISE--IT EXEMPTS ACUTE CARE FACILITIES FROM THE COSTLY AND UNNECESSARY CON PROCESS.

SENATOR HALLIGAN'S BILL IS THE WRONG BILL AT THE WRONG TIME.

I URGE YOUR SUPPORT FOR SB 340.

THANK YOU.

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE

PRINTED NAME

ADDRESS

Cindy K. Leenkreicht	Cindy K. (Tiams) Leenkreicht	611 Sapphire Bldg MT 59105
Walter Reichenberg	Walter Reichenberg	96 North 2nd St. Billings
K P Lucien	K P LUCIEN	1132 Ave F Bldg Mt
Shawna McBride	Shawna McBride	3121 10th Ave N Bldg MT 59101
Jerry Stagler	Jerry STAGLER	3543 Creek Billings MT
Marguerite Galk	Marguerite Galk	2600 Terrace Dr. Bldg
Katherine Maurakis	Katherine Maurakis	135 Burlington Bldg Mt
GUS MAURAKIS	GUS MAURAKIS	135 Burlington Bldg MT
Donothy Leone	Donothy LEONE	1298 Governors
Kera Reineking	Kera Reineking	1724 Muriposa
Lyle Lathram	Lyle Lathram	4 Radio Plaza Bldg - 59102
MONIQUE LUX	MONIQUE LUX	3842 N. Janora
Ralph Pelison	Ralph Pelison	Elm Creek Bldg 59101
AUNGERHART	AUNGERHART	3307 Spruce St.
ROSE GOUNTANIS	ROSE GOUNTANIS	1105 W. 26th
LYDIA RESSET	LYDIA RESSET	1039 Center Ave Bldg MT 59102
JAMES G. MILLIGAN	JAMES G. MILLIGAN	1635 Bitterroot Dr Bldg 59105
LEE R McDaniel	LEE R McDaniel	2315 Cotton Bldg - 1395 MT 59102
MARVIN H CRICK	MARVIN H CRICK	5010 Rimrock Rd 59102
Helmer Haagenen	Helmer Haagenen	1542 Canary 59101
JOE P BESSO	JOE P BESSO	1923-12th St West
George P. Linsky	George P. Linsky	1025 Howard Ave Bldg
Ruth Larson	Ruth LARSON	1935 Lake Elm Dr.
J. E. FRY	J. E. FRY	1746 Park Blvd Dr
Virginia Lathorn	Virginia Lathorn	4 Radio Plaza
ROYAL DANKC.4Y Mt.	ROYAL DANKC.4Y Mt.	
135 Bld. Case	135 Bld. Case	Bldg. Mt. 59101
2010-16th NW	2010-16th NW	Billings MT 59107
2115 George St	2115 George St	Billings
2206 Howard	2206 Howard	Billings
769 Yellow Line #30	769 Yellow Line #30	Billings 59105

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One	
			Support	Oppose
John F. Adams	Mont. Hospital Association		340	217
Steve Waldron	Mental Health Centers		217	340
Bob Johnson	MT Assoc. Home-Health (Nurse)		SP217	340
Kyle Hopstad	France Mahon Deaconess		217	340
Pat Melby	Penrose Foundation		217	340
Donna Rasmussen	Shelton Memorial Hospital		340	217
John R. Rasmussen	Deaconess - Mt. Pacific - Billings		217	340
John R. Rasmussen	Deaconess - Mt. Pacific - Billings		217	340
Mike Key	Agency for IHC/Mental Health LLC		217	340
ALAN KEY	MONTANA HEALTH NETWORK		217	340
Eric Lindmark	Mont. Hosp. Assn.		340	217
Paul Casey	Spokane Hosp.		340	217
Wingardner	Medical Association		217	340
Paul Rasmussen	Health Marketing Assoc.		217	340
Roger Sturgeon	Mt. St. Helens Care Area		217	340
Greg M. Sturgeon	CD PM		217	340
John Cunningham	Remick - Fed.		217	340
John Stump	Remick Foundation		217	340
John J. Telmer MD	Montana Medical Association		340	217
Richard Brown	Liberty County Hospital		340	217
William L. Weller	Montana Hosp. Assn.		340	217
William L. Weller	MHCA		217	340
Wanda Jansson	LMT C	217	✓	
Wanda Jansson	RMT, Deaconess	340		✓
Wilbur Schumann	Montana Nurses Assoc.		217	340
Wanda Jansson	Bozeman Care Center		217	340

(Please leave prepared statement with Secretary)

2/10/87

DATE _____
Public Health _____

—BILL, NO. 217

SB 217
SB-340

NAME

Check One

Support	Oppose
---------	--------

[illegible]

(Please leave prepared statement with Secretary)

NAME	REPRESENTING	BILL #	Check One	
			Support	Oppose
Bill McDonald	Common Medical Center		340	217
John Smith	Rocky MT Treatment Center	217	340	217
Fred Patterson	KARP	217	X	
		340		X
John Lewis	KARP	217	X	
" "	"	340		X
John Smith	Rocky Mountain Home - Helena	217	X	
" "	"	340		X

(Please leave prepared statement with Secretary)

Discussion: Senator Rasmussen explained that the amendments actually blend SB 217 and SB 340 together. It brings SB 340 into SB 217. SB 217 is being used as the vehicle to remove the Sunset provision regarding the Certificate of Need, and then the hospitals would be exempted from the process.

Chairman Hager stated that two things that SB 217 does that SB 340 does not do is (1) SB 217 gets rid of the Sunset provision, and (2) SB 217 deletes the requirement that the Department of Social and Rehabilitation Services report to the Legislature concerning Medicaid funding and recommending future funding levels.

Senator Hims1 inquired that if SB 217 was not passed, would the CON sunset for everybody concerned. Senator Hager stated that was correct. Senator Hims1 stated that from his experience he is now convinced that CON is a financial burden.

Recommendation and Vote: Senator Rasmussen made a motion to amend SB 217. Senators in favor, 3; opposed, 4.

Senator Norman made a motion that SB 217 DO NOT PASS.
Senators in favor, 6; opposed, 1 (Rasmussen).

EXECUTIVE ACTION ON SB 340

Chairman Hager called for action on SB 340:

Discussion: Discussion centered around the Sunset provision. Senator Lynch stated that SB 340 extends the CON for everyone for another two years with the exception of hospitals.

Tom Gomez advised that there was a technical amendment to be added on page 4, line 17. He explained the amendment and the need for it.

Recommendation and Vote: Senator Lynch made a motion that the amendment be adopted. Senators in favor, 6; opposed, 1 (Norman).

Senator Lynch made a motion that SB 340 DO PASS AS AMENDED.
Senators in favor, 5; opposed 2 (Hims1, Norman).

EXECUTIVE ACTION ON SB 299

Chairman Hager called for action on SB 299: He advised that this bill was introduced at the request of the Board of Hearing Aid Dispensers. He stated that Senator Norman

PUBLIC HEALTH

COMMITTEE

51st LEGISLATIVE SESSION -- 1989

Date

2/12/89

NAME	PRESENT	ABSENT	EXCUSED
Sen. Tom Hager	X		
Sen. Tom Rasmussen	X		
Sen. Lynch	X		
Sen. Hims1	X		
Sen. Norman	X		
Sen. McLane	X		
Sen. Pivnich	X		

Each day attach to minutes.

SENATE STANDING COMMITTEE REPORT

February 14, 1989

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety, having had under consideration SB 340 (first reading copy -- white), respectfully report that SB 340 be amended and as so amended do pass:

1. Page 4, line 17.

Following: "hospital"

Insert: ", except to the extent that a hospital is subject to certificate of need requirements pursuant to subsection (1)(1)"

AND AS AMENDED DO PASS

Signed: _____
Thomas O. Hager, Chairman

Amendments to Senate Bill No. 340
First Reading Copy

For the Senate Public Health, Welfare and Safety Committee

Prepared by Tom Gomez, Staff Researcher
February 13, 1989

2-13-89
SENATE HEALTH & WELFARE

DATE

BILL NO.

Committee

1. Page 4, line 17.

Following: "hospital"

Insert: ", except to the extent that a hospital is subject to
certificate of need requirements pursuant to subsection (1)(i)"

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH

Date 2/13/89 Bill No. SB 340 Time 1:25

NAME	YES	NO
SEN. TOM HAGER	X	
SEN. TOM RASMUSSEN	X	
SEN. LYNCH	X	
SEN. HIMSL	X	
SEN. NORMAN		O
SEN. McLANE	X	
SEN. PIPINICH	X	

Louise Sullivan
Secretary

Sen. Tom Hager
Chairman

Motion: Motion (Sen Lynch.) Amendment Adg
In Favor - ~~all~~ 6
Opposed - No - 1

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH

Date 2/13/89 Bill No. SB 340 Time

NAME	YES	NO
SEN. TOM HAGER	X	
SEN. TOM RASMUSSEN	X	
SEN. LYNCH	X	
SEN. HIMSL		O
SEN. NORMAN		O
SEN. McLANE	X	
SEN. PIPINICH	X	

Louise Sullivan
Secretary

Sen. Tom Hager
Chairman

Motion: To Do Pass As Amended
5 in favor
2 Opposed

STATUS SHEET

LEGISLATIVE SESSION

HUMAN SERVICES AND AGING

COMMITTEE

BILL NUMBER	ENTERED COM. DATE	DATE CON- SIDERED	OUT OF COM.	DO PASS DATE	DO NOT PASS DATE	DO PASS AS AMENDED DATE	DO NOT PASS AS AMENDED DATE	BE CON- CURRED IN DATE	BE NOT CON- CURRED IN DATE	BE CON- CURRED IN AMENDED DATE	BE NOT CONCURRED IN AS AMENDED DATE
SB189	2.27.89	3.6.89	3.6.89					3.6.89			
SB214	2.27.89	3.13.89	3.13.89					3.13.89			
SB272	2.27.89	3.8.89	3.15.89							3.15.89	
SB289	2.27.89	3.8.89	3.8.89					3.8.89			
SB311	2.27.89	3.13.89	3.15.89							3.15.89	
SB342	2.27.89	3.3.89	3.3.89							3.3.89	
SB352	2.27.89	3.8.89	3.15.89								
SB372	2.27.89	3.8.89	3.15.89					3.15.89			
SB399	2.27.89	3.8.89	3.15.89					3.15.89			
SB407	2.27.89	3.13.89	3.13.89					3.13.89			
SB426	2.27.89	3.13.89	3.15.89					3.15.89			
SB437	2.27.89	3.13.89	3.13.89							3.13.89	
SB454	2.27.89	3.13.89	3.13.89					3.13.89			
SR114	2.27.89	3.13.89	3.13.89					3.13.89			

Use a separate sheet for Senate Bills, House Bills, and Resolutions.

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
51st LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES AND AGING

Call to Order: By Stella Jean Hansen, Chairman, on March 3, 1989
at 3:00 p.m.

ROLL CALL

Members Present: All /

Members Excused: None

Members Absent: None

Staff Present: Mary McCue, Legislative Council

Announcements/Discussion: None

HEARING ON SB 340

Presentation and Opening Statement by Sponsor:

Senator Williams stated that this bill was an act to revise and continue the certificate of need laws; to exempt hospitals from certificate of need requirements in certain circumstances; and providing an effective date.

Testifying Proponents and Who They Represent:

Rep. Bob Marks
Jim Aherns, Montana Hospital Association
Rep. Dave Brown
Richard Brown, Liberty County Hospital
Hollis LeFever, M.D.
Jerry E. Jurena, Trinity Hospital
Sandra Erickson, Montana Associated Physicians
Grant Winn, Missoula Community Hospital
Jerry Beaudette, Sheridan Memorial Hospital
Ed Sheehy, National Association of Retired Persons
Lawrence McGovern, Montana Associated of Physicians
James T. Paquette, St. Vincent Hospital and Health Center
Jerry Loendorf, Montana Medical Association
John Guy, St. Peter's Hospital
Jack Casey, Shodair Hospital

Proponent Testimony:

Rep. Bob Marks stated that health care costs are high. The federal government gave up on certificate of need in 1986. The National Health Planning Act was scheduled to be re-authorized as early as 1981 but it never was. Congress merely funded it with the

continuing resolution year after year until 1986 when it said enough is enough. Each year the federal participation in certificate of need activities grew smaller and smaller until it finally faded away. In Montana the agency with certificate of need once employed over 16 FTE's and now that the federal government has ceased, it is budgeted at less than 5 FTE's and it is staffed even less than that. It is time to have the competitive market to reduce health care costs. If health care facilities engage in unwise, unneeded, overly expensive procedures which their communities cannot support with utilization, let them pay the consequences. Rep. Marks stated that it is his belief that not many health care facilities would be willing to take that risk. Self regulation will prevail. This bill removes hospitals from the certificate of need and hospitals are less in need of capital regulation than are other providers. If hospitals are taken from certificate of need this year, and extend the certificate of need for the other health care facilities, and watch very carefully to see if the doom and gloom results which proponents of certificate of need say will result, the next session can come back in and place hospitals in under the certificate of need law. If costs go down in two years the legislature should start thinking about reducing the scope of certificate of need even further.

Jim Ahrens stated that the Montana Hospital Association represents 54 hospitals and 31 attached nursing homes throughout the state. It has been characterized as a compromise bill and it is just that. It is the compromise between those who want no certificate of need for anyone and those who want certificate of need forever for all providers. This bill extends certificate of need for two years and exempts hospitals for certain services. Exhibit 1.

Rep. Dave Brown stated that he was convinced that after visiting with the hospitals in his area, that this legislation is imperative. Certificate of need does nothing but drain dollars from hospitals operating budgets. Quality of care is not the issue, trying to regulate competition amongst a sector. Rep. Brown also stated that he wondered why there is such a push in the other areas to retain certificate of need. Is there some intent to maintain a monopoly situation and prevent private competition in the certificate of need area. That is a very real question that the committee should consider. If just hospitals are out of this bill, then this bill should die.

Richard Brown stated that as an administrator of a small rural hospital, it does not allow him to make unwise business decisions regarding programs and

business and capital investments. When the decision is made to pursue new programs to consider equipment purchases or building projects, hospital go through very methodical processes of their own to determine the need and feasibility. Hospitals must make decisions on capital investments and programs in a very business-like manner. Exhibit 2.

Hollis LeFever, M.D. stated that the certificate of need law does not certify need, it certifies legal and political power to serve sociopolitical pressures. It does not limit cost to patients and taxpayers. It only limits availability; availability of needed services. Exhibit 3.

Jerry E. Jurena stated that if the intent of certificate of need is to assure quality, it has missed the boat. If it is to restrict the access of health care and limit the technologies associated with building or remodeling, then it is working, if certificate of need is an asset, why hasn't other industries introduced this type of restrictive legislation? Exhibit 4.

Sandra Erickson stated that certificate of need process guide Montana in development and growth based on the documented need of those services. Montana treatment facilities have witnessed unbridled growth in neighboring states and they have ultimately resulted in reduced quality of care, reduced occupancy rates, reduced treatment options and left the field of chemical dependency treatment in shambles. Exhibit 5.

Grant Winn stated that in Missoula there was a hospital that received a certificate of need that was not needed and ultimately was absorbed by another hospital. A certificate of need was submitted last year for an expansion of the hospital with absolutely no opposition and the application itself was \$28,000.00. Certificate of need for hospitals has been a waste.

Jerry Beaudette stated that this bill is a step towards total elimination of the certificate of need process. Mr. Beaudette also said that within a year of the completion of the facility his community had under way, all 20 beds were full and have been so ever since. This is a step closer towards total elimination of the certificate of need process.

Ed Sheehy said that he supported this bill.

Lawrence McGovern stated that he supported this bill.

Jim Pacquette stated that there is no proof that certificate of need law reduces costs to the consumer;

there is supporting documentation that certificate of need legislation raises costs of operation to hospitals and that certificate of need law is a clear restraint of trade and hinders the ability of hospitals to function in the free marketplace. Exhibit 6.

Jerry Loendorf stated his support of this bill.

John Guy stated that he supported this bill.

Jack Casey stated his support of this bill.

Testifying Opponents and Who They Represent:

Rose Hughes, Montana Health Care Association
Chuck Butler, Blue Cross and Blue Shield
Wilbur Rehman, Montana Nurses Association
Mona Jamison, Rocky Mountain Dependency Center
Fred Patton, American Association of rEtired Persons
Joan Ashley, Cooney Convalescent Hospital
Steve Waldron, Mental Health Center
Mike Cahill, Granite County Hospital

Opponent Testimony:

Rose Hughes stated that it was with reluctance that she spoke in opposition against this bill because the association would not be thrilled if it failed. Ms. Hughes then proposed some amendments to the bill. A packet was also presented which contained information on the high cost of deregulation; the move at the federal level to reinstate certificate of need; excess capacity and high costs and the unconstitutionality to exempt hospitals. Exhibit 7.

Chuck Butler stated that Blue Cross and Blue Shield supports the continuation of certificate of need with the amendments. The hospital community should be included in the certificate of need process. As Montana's largest insurer of health care, it is known first hand the effect of these rising costs on the people of Montana. Health care costs are one of the fastest if not the fastest growing expenses for employers and employees in our state and country. Mr. Butler stated that the health care insurers have lost money because they could not charge enough in the last three years to cover the actual costs that have been paid out.

Wilbur Raymond stated his support of the certificate of need process. If the bill were amended to include hospitals it would be a good bill. If certificate of need were done away with we would have a brighter future for the cost of health care. That is not true. The issue is really the issue of public involvement and public trust.

Mona Jamison stated that she supports this bill however, the issue of compromise was discussed. How can we compromise among ourselves and not have everyone mad in terms of the bill as presented. The amendments were supported as proposed. The amendments make clear that if hospitals do get into providing the other services, that it is the legislature's intent that the initial provision of those services or expansion that they do comply with certificate of need.

Fred Patton stated that this would not slow the rate of health care costs there would be duplication of expensive equipment and facilities. There would be no longer any rational planning of health care facilities.

Joan Ashley supports the amendments of this bill.

Steve Waldron stated his support of the amendments.

Mike Cahill stated his opposition of the bill.

Questions From Committee Members: Rep. Gould asked Ms. Erickson why she was afraid of competition and Ms. Erickson stated that there would be a need for affordable chemical dependency treatment and that there is an increase every year of people being admitted for the first time.

Rep. Good asked Mr. Robinson about the Wyoming situation regarding certificate of need and also questioned the constitutionality.

Rep. Simon asked Mr. Aherns about swing beds and long term care. and Mr. Aherns said that if a hospital did in fact want to expand to a swing bed facility they would be required to complete a certificate of need. Rep. Simon then again asked where this was read in the bill and Mr. Aherns said it was contained on page 4, section h. Rep. Simon then stated that this bill excludes the exemption of hospitals in section (1) (i).

Rep. Russell asked Mr. Aherns about health care facilities.

DISPOSITION OF SB 340

Motion: Rep. Simon made a Motion to BE CONCURRED IN.

Amendments, Discussion, and Votes: Rep. Simon made a Motion to move the Statement of Intent. A vote was taken on the Statement of Intent and all voted in favor. Motion carries.

Recommendation and Vote: A vote was taken TO BE CONCURRED IN WITH A STATEMENT OF INTENT. All voted in favor. Motion carries.

Closing by Sponsor: Senator Williams closed on the bill.

HEARING ON SB 124

Presentation and Opening Statement by Sponsor:

Senator Hager stated that bill was an act prohibiting a long term health care facility from refusing to admit a person to the facility solely because that person has aids or any other HIV-related condition.

Testifying Proponents and Who They Represent:

Bob Johnson, Montana Public Health Association
Mary Beth Frideres, Montana Aids Coalition
Sandy Hale, Montana Women's Lobby
Ann McIntyre, Human Rights Division
Wilbur Rehman, Montana Nurses Association

Proponent Testimony:

Bob Johnson stated that every hospital and nursing home in the state in coming years in Montana will be faced with the responsibility for admitting people with Aids. The staffs of these institutions have been trained in universal procedures that will allow them to treat Aids effectively and to protect the staffs of those institutions. There is virtually no health reason why any institution should be allowed to refuse to admit somebody who has Aids based upon health reasons.

Mary Beth Frideres supports this bill. There is no medical or scientific reason why we cannot take care of people with this infection. Technology has advanced and is appropriate and available to take care of people. There are procedures to be put in place to take care of individuals and there is no reason to discriminate on the basis of HIV infection for providing health care.

Sandy Hale stated that they endorse measures to prevent the human and economic loss relating to Aids. They support the adoption of a strong and comprehensive state level Aids policy including provision for the adequate resources and funding for prevention, education and direct care; opposition for mandatory testing; provisions for informed consent, adequate counselling and confidentiality in conjunction to HIV antibody testing. Exhibit 8.

Anne McIntyre stated that she had amendments to supply for the committee. The Human Rights Division has taken the position that these laws prohibit discrimination against someone who has an HIV related condition. This interpretation is similar to the position taken by

HUMAN SERVICES AND AGING COMMITTEE

Date 3/3/89

[illegible]

STANDING COMMITTEE REPORT

March 4, 1989

Page 1 of 1

Mr. Speaker: We, the committee on Human Services and Aging report that SENATE BILL 340 (blue reading copy), with statement of intent included, be concurred in as amended.

Signed: _____
Stella Jean Hansen, Chairman

[REP. MARKS WILL CARRY THIS BILL ON THE HOUSE FLOOR]

And, that such amendment read:

1. Page 1.

Following: line 16

Insert: " STATEMENT OF INTENT

It is the legislature's intent to exclude acute care hospitals from certificate of need requirements, except in certain limited circumstances that are enumerated in subsections 50-5-301 (1) (h) and 50-5-301 (1) (i). The provision by a hospital of services under either of those subsections is intended to include construction, conversion, or expansion of bed capacity."

TESTIMONY BEFORE HOUSE HUMAN SERVICES AND AGING COMMITTEE

ON

SENATE BILL 340

BY

MONTANA HOSPITAL ASSOCIATION

MADAM CHAIRMAN, MEMBERS OF THE COMMITTEE, MY NAME IS JAMES AHRENS; I AM THE PRESIDENT OF THE MONTANA HOSPITAL ASSOCIATION. THE ASSOCIATION REPRESENTS 54 HOSPITALS AND 31 ATTACHED NURSING HOMES THROUGHOUT THE STATE. THE MONTANA HOSPITAL ASSOCIATION SUPPORTS SENATE BILL 340. IT HAS BEEN CHARACTERIZED AS A COMPROMISE BILL, AND IT IS JUST THAT. IT IS THE COMPROMISE BETWEEN THOSE WHO WANT NO CON FOR ANYONE, AND THOSE WHO WANT CON FOREVER FOR ALL PROVIDERS. THIS BILL EXTENDS CON FOR TWO YEARS AND EXEMPTS HOSPITALS FOR CERTAIN SERVICES.

THE ASSOCIATION I REPRESENT DOES NOT FAVOR CON. WERE IT POLITICALLY ACHIEVABLE, WE WOULD PREFER TO SEE CON SUNSET IN ITS ENTIRETY. HOWEVER, WE RECOGNIZE THAT OTHER PROVIDERS MAY NOT SHARE OUR DISTASTE FOR CON. RATHER THAN PROVOKE A CONFLICT, WE DECIDED TO RESPECT THE WISHES OF THOSE PROVIDERS AND SUPPORT A BILL THAT WOULD CONTINUE CON FOR THEM, BUT SIMPLY EXEMPT HOSPITALS. THE CON PROTECTION, THE CON FRANCHISE, WOULD STILL BE EXTENDED TO NURSING HOMES, INPATIENT CHEMICAL DEPENDENCY AND INPATIENT PSYCHIATRIC TREATMENT FACILITIES AS WELL AS TO HOME HEALTH AGENCIES, HOSPICES, PERSONAL CARE SERVICES AND INPATIENT REHABILITATION SERVICES. MORE THAN THAT, IF A HOSPITAL WANTED TO ENGAGE IN ANY OF THESE PROTECTED SERVICES, IT WOULD HAVE TO OBTAIN A CON.

EXHIBIT 1
DATE 3-3-89
HB 340

YOU HAVE NO DOUBT HEARD A LOT ABOUT CON IN THE LAST FEW WEEKS. THE WITNESSES THAT FOLLOW ME WILL TELL YOU MORE OF THE REASONS WHY CON IS NOT NECESSARY FOR HOSPITALS. THEY HAVE TRAVELED TOO FAR FOR ME TO GIVE THEIR TESTIMONY, SO I WILL MAKE MY REMARKS BRIEF AND CONFINE THEM TO THE REASONS WHY THIS IS THE CON BILL YOU SHOULD VOTE FOR--WITH NO AMENDMENTS. THIS IS A GOOD BILL AND IT NEEDS NO AMENDMENT.

THERE WERE TWO CON BILLS INTRODUCED IN THE SENATE. THE FIRST ONE, SENATE BILL 217, SIMPLY REMOVED THE SUNSET PROVISION OF EXISTING LAW, SO THAT CON WOULD CONTINUE INTO PERPETUITY. HOSPITALS WERE NOT INVITED TO PARTICIPATE IN THE CRAFTING OF THAT BILL. WE WERE SIMPLY TOLD, "YOU WILL BE IN CON...FOREVER."

SENATE BILL 217 NEVER MADE IT OUT OF COMMITTEE, BECAUSE THE SENATE PUBLIC HEALTH COMMITTEE SAW THE WISDOM OF 1) REMOVING HOSPITALS FROM CON AND 2) ESTABLISHING A SUNSET PROVISION.

THE COMMITTEE BELIEVED THAT IT WAS NO LONGER NECESSARY FOR HOSPITALS TO BE SUBJECT TO CON. THEY BELIEVED THAT THE COMPETITIVE MARKET USHERED IN BY THE MEDICARE PROSPECTIVE PAYMENT SYSTEM PROVIDED MORE EFFECTIVE COST CONTROL THAN CON EVER DID. THEY BELIEVED THE FEDERAL TRADE COMMISSION REPORT THAT STATED CON, BECAUSE IT INHIBITED COMPETITION, ACTUALLY DROVE UP HEALTH CARE COSTS, AND THEY BELIEVED THE REPORT FROM THE LEGISLATIVE AUDITOR OF MONTANA WHO, AFTER STUDYING CON FOR TWO YEARS AT THE DIRECTION OF THE LEGISLATURE, CAME TO THE CONCLUSION THAT "IT IS DIFFICULT TO ASCERTAIN WHETHER MONTANA'S CON PROGRAM HAS BEEN EFFECTIVE ENOUGH TO CONTINUE BEYOND JUNE 30, 1989." THE COMMITTEE FELT IT WAS NECESSARY TO RETAIN A SUNSET PROVISION BECAUSE A SUNSET DATE PROVIDES FOR A PROGRAMMED REVIEW OF CON. A

PROGRAMMED REVIEW OF CON IS NECESSARY BECAUSE 1) THE EFFECTIVENESS OF THE PROGRAM IS STRONGLY QUESTIONED AND 2) THE RELATIONSHIP BETWEEN REGULATORS (THE CON AGENCY) AND THE REGULATED (THE NURSING HOME AND CHEMICAL DEPENDENCY INDUSTRIES) DESERVES LEGISLATIVE OVERSIGHT TO PROTECT THE PUBLIC INTEREST. THE LEGISLATIVE AUDITOR COULD NOT SAY THAT CON WAS EFFECTIVE. ALL OF THE ROCKY MOUNTAIN STATES HAVE TERMINATED THEIR CON PROGRAMS AND THEY HAVE BEEN JOINED BY A NUMBER OF OTHERS. WE HOPE IN TWO MORE YEARS THERE WILL BE STUDIES THAT ENABLE US TO SAY DEFINITELY THAT CON DOES NOT WORK, THAT IT IS AN EXPENSIVE AND BURDENSOME PROGRAM WHOSE SOLE PURPOSE IS TO DOLE OUT FRANCHISES TO PROVIDERS WHO DO NOT WANT TO COMPETE.

THE SENATE PUBLIC HEALTH COMMITTEE KILLED SENATE BILL 217 AND FOUGHT BACK AN ATTEMPT TO AMEND SENATE BILL 340 BY REMOVING THE SUNSET AND PUTTING HOSPITALS BACK IN. ON THE SENATE FLOOR, THE PROPONENTS OF SENATE BILL 217, ATTEMPTED TO OVERTURN THE ADVERSE COMMITTEE REPORT. THEY FAILED. ON SECOND READING OF SENATE BILL 340, THE PROPONENTS OF SENATE BILL 217 ATTEMPTED TO AMEND THIS BILL BY REMOVING THE SUNSET AND BY WIDENING THE NUMBER OF SERVICES FOR WHICH A HOSPITAL MUST OBTAIN A CON. BOTH AMENDMENTS FAILED AND THE BILL PASSED SECOND READING 48-0. IT PASSED THIRD READING 49-1, THE ONE SENATOR VOTING AGAINST IT, VOTING SO BECAUSE HE WANTED CON TO SUNSET IN ITS ENTIRETY.

YOU MAY HEAR SOME PEOPLE TESTIFY TODAY THAT TAKING HOSPITALS OUT OF CON WILL HAVE A HARMFUL EFFECT ON THE MEDICAID BUDGET. THOSE WHO MAKE THAT CLAIM DO NOT UNDERSTAND THE REIMBURSEMENT SYSTEM FOR MEDICAID. MEDICAID REIMBURSES HOSPITALS FOR INPATIENT SERVICES ON THE BASIS OF DIAGNOSTIC RELATED GROUPS

EXHIBIT
DATE 3-3-89
HB 340

(DRGs). THIS IS A FIXED RATE PAYMENT SYSTEM BY WHICH EVERY HOSPITAL IN THE STATE RECEIVES THE SAME PAYMENT FROM MEDICAID FOR PROVIDING CARE. SRS SETS THE WEIGHTS FOR DRGs. THAT IS, SRS DETERMINES IF, SAY GALL BLADDER SURGERY SHOULD BE PAID AT A RATE TWICE THAT OF A TONSILLECTOMY. THE LEGISLATURE IS RESPONSIBLE FOR GRANTING ANNUAL INCREASES TO THE DRG PRICE, BUT IT CANNOT EXCEED THE AMOUNT SET BY THE FEDERAL CONGRESS ACCORDING TO ITS AUTHORITY IN THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982.

THESE PRICES ARE SET WITHOUT REFERENCE TO ACTUAL HOSPITAL COSTS. SO, MEDICAID PAYMENTS ARE SET BY SRS AND THE LEGISLATURE. INCREASES IN COST ARE DO TO AN INCREASE IN UTILIZATION AND CASE COMPLEXITY. BOTH OF THESE FACTORS ARE BEYOND OUR CONTROL.

FURTHERMORE, SRS HAS NEVER SHOWN ITS CONCERN FOR CAPITAL REGULATION DURING THE ACTUAL CON PROCESS. NOT ONCE IN THE LAST FOUR YEARS HAS SRS TESTIFIED ON A HOSPITAL CON APPLICATION. THE CONTENTION THAT TAKING HOSPITALS OUT OF CON WILL RAISE THE ROOF ON THE MEDICAID BUDGET IS SIMPLY BASED ON MISINFORMATION.

THIS IS A GOOD BILL. IT IS THE COMPROMISE BILL. WE URGE YOU TO ACCEPT IT AS IS. I WOULD BE HAPPY TO SPEAK TO ANY SUGGESTIONS FOR AMENDMENT, IF ANY ARE MADE. HOSPITALS DO NOT WANT TO BE UNDER CERTIFICATE OF NEED. IF OTHERS DO, LET THEM.

State of Montana
Office of the Legislative Auditor

REPORT TO THE LEGISLATURE

CERTIFICATE OF NEED PROGRAM

DEPARTMENT OF HEALTH
AND ENVIRONMENTAL SCIENCES

This report provides information regarding the
Certificate of Need program and identifies areas
for legislative consideration.



Direct comments/inquiries to:
Office of the Legislative Auditor
Room 135, State Capitol
Helena, Montana 59620

88P-33

EXHIBIT 1
DATE 3-3-89
HS 340

Nursing Home, an 11 bed acute care and 40 bed skilled nursing facility located in Chester. I have been the administrator of that facility for eleven years. Currently I am serving as Chairman of the Montana Hospital Association.

I am here today to speak in support of Senate Bill 340 (Williams) which would continue Certificate of Need (C.O.N.) and exempt hospitals from most services, all equipment and all construction. This bill would still require C.O.N. for swing beds, long term care beds, psycho, rehab and chemical dependency services. The bill in its present form addresses the concerns of most health care provider organizations.

As the Administrator of a small, rural hospital I am in a position that does not allow me to make unwise business decisions regarding capital investments. When the decision is made to pursue a new program, consider an equipment purchase or building project, hospitals go through a very methodical process of their own to determine need and feasibility. Hospitals must make decisions on capital investments and programs in a very business like manner. The questions asked by hospital administrators as they determine the need for these projects or programs, are the same questions asked in the C.O.N. application. This duplication only adds to the rising cost of health care and creates another obstacle in the efforts of hospitals to run an efficient operation.

EXHIBIT 2
DATE 3-3-89
HR 340

I don't deny that health planning is beneficial but the needs within our individual communities and around the state will determine whether or not additional health care facilities should be constructed or whether additional equipment should be purchased for providing services. I have had occasion to go through the C.O.N. process for program change and equipment purchases. Those incidents were time consuming, and expensive use of resources, and in my opinion a duplication of process. In addition these programs were delayed for implementation until the application could go through a lengthy, unnecessary cycle. In essence the entire process is very ineffective. Our decision to pursue these projects was driven by the needs of the residents we were serving. Nothing was done frivolously or without thought. That type of approach would only lead to the eventual demise of our hospital.

The Certificate of Need process is no longer effective for Montanas' hospitals. Ideally the sunset of the C.O.N. law would be in the best interest of health care organizations throughout the state. I do however support Senate Bill 340 in its' current form and urge the passing of this Bill. Any amendment to the Bill would only dilute the intent of the Legislation.

Thank you for your consideration.

EXHIBIT 2
DATE 3-3-89
HB 340

HOLLIS K. LEFEVER, M.D. FAAFP
LEWISTOWN, MT. 59457

DIPLOMATE AMERICAN BOARD
OF FAMILY PRACTICE

I speak in favor of SB 340. The certificate of need law does not certify need, it certifies legal and political power to serve sociopolitical pressures. It does not limit cost to patients and taxpayers. It only limits availability; availability of needed services. I have spent 31 years trying to bring patients and services together in Montana.

The certificate of need law 50-5-301, part 3, may be referred to as the State Franchise Bill, it was initially conceived to prevent unnecessary duplication of health care facilities, equipment and services that would result in extra cost to the health care recipients or the public through the expenditures of tax funds. The law has failed miserably to accomplish these goals and is no longer a necessary obstacle in the provision of health care in Montana. Indeed, the bill has never proved cost saving measure and has cost the health care industry in Montana literally millions of dollars as well as the tax payers of Montana who are spending over a quarter of a million dollars annually just to keep the State Department funded to oversee the certificate of need law. Only a third of the expense for the operation of the State Department responsible for the enforcement of this law is paid by health care providers. Even so, the amount paid by health care providers is a considerable burden to each health care facility attempting to improve it's ability to provide current state-of-the-art health care. The bill has been demonstrated to invite bias, excessive socioeconomic & political pressures, and to not only hamper the effort at facilities to provide needed services but to saddle the patients in our facilities with tremendous extra cost involved in funding the certificate of need process. Indeed, Montana is remiss in not having repealed this law much sooner. We are the only Rocky Mountain State to still have such a law in the books. Our neighbors Arizona, Colorado, Idaho, New Mexico, Utah, and Wyoming do not have such a law. California, Texas, Kansas, and Minnesota have rejected this type of legislation. The law includes, among other undesirable elements, a restraint of trade. The Federal Trade Commission reported that CON grants a franchise and inhibits competition and thereby increases health care costs. In September of 1986, Congress suspended all funding for CON and CON related agencies because it did not reduce cost. The Federal Government, through the Medicare Program does not pay hospitals according to the money they spend. Hospitals are reimbursed according to the diagnoses of the diseases they care for. Excessive expenditures to care for those diseases would only jeopardize the hospitals financial stability. No additional federal reimbursement would be received because the hospital expended unnecessary funds to provide facilities, services, or equipment. The DRG law ended that. Indeed the only rational way to justify expenditures in the 1989 scene of health care and all the demands that are made for cost containment and quality

EXHIBIT 3

DATE 3-3-89

2-14

PAGE TWO.

care, is to allow individual facilities to make capital investment decisions based upon community needs, availability of the service in the area, the volume of the potential demand for the service, and the ability of the health care consumer to pay for the service so that the facility will be able financially to continue to provide the service with the reimbursement it can obtain for it. Having considered these factors and made an intelligent decision, health care facilities administrations and boards should not be hampered by second guessing at a State level, particularly when that second guess, namely the CON review process, is so costly and time consuming & comparatively uniformed about local needs.

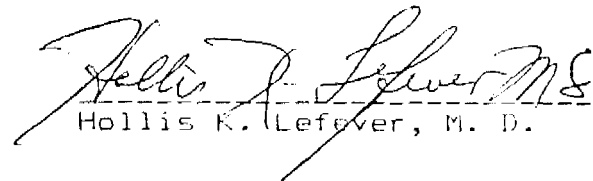
What are these costs? First of all, there is a major cost simply to file the application with the State to obtain a certificate of need. Second, there are large costs in obtaining legal and financial feasibility studies to accompany the application, and third, there are great costs in time and services of institutional personnel to gather all of the data and information needed to submit a CON application. And, let's don't forget that while all of this is going on (a process which has been proven to take months and even years in Montana) that service is being denied to the patient's in the area and the revenue from that service is being denied the facility which is trying to survive in this age of economic realities in the health care field. Twelve States have eliminated this type of legislation so that the health care industry was deregulated. Those areas have not seen excessive growth in the provision of services for acute care.

I have been watching the needs and the attempts to meet these needs in Montana since 1958. I have been in the private practice of medicine. I have tried to deal with these problems as a physician admitting patient's to acute care hospitals in Glendive and in Lewistown. I have tried to provide services while serving as President of the Medical Staff and Boards of these hospitals, I have watched the health care needs in the State as past president of the Montana Medical Association, and I have heard the certificate of need presentations as I served on the area health council. I have watched the frustration and humiliation of hospital administrators presenting applications where the cost of the applications far exceeded the cost of providing the service. I have watched patients in communities do without needed services either because of denial under the certificate of need law, or the fear of denial, or the fear of the expense in attempting to obtain a franchise to provide a much needed facility, service or equipment. The small hospitals in which I work and the smaller hospitals than that, don't have tens of thousands and hundreds of thousands of dollars to spend on legal fees, surveys and application fees. They have a hard enough time scraping together the dollars to buy a piece of X-ray equipment or to set up a surgery suite or to create a certain type of acute care bed that is critically needed. I well remember our committee hearing the applications of a facility where

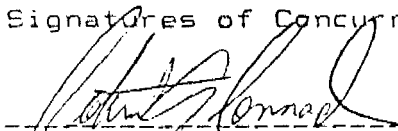
EXHIBIT 3
DATE 3-3-89
HB 340

PAGE THREE.

twice as much money was spent obtaining a certificate need as was needed to move an X-ray unit from a Physician's office into the hospital. This was not only absurd, it was unconscionable in this day and age of limited funds and almost unlimited health care needs for our citizens. Now that the certificate of need is determined by the State Department of Health & Environmental Science, some of the steps have been eliminated but it has not reduced the cost, uncertainty, and erroneous decisions that could be avoided if the CON law were simply allowed to die at this time. We have seen the State approve CON's for facilities when those of us in the health care industry watched with dismay and could not believe that they could have been approved, and at the same time we have watched the State deny CON's only to have them overturned in court. How long will you, our respected Legislators, perpetuate this folly? If indeed you feel that long term care facilities and psychiatric and drug abuse services would proliferate without the law, then accept Senator William's compromise bill, Senate Bill 340. But, please remove the hobbles from the feet of those of us who are trying to provide health care services to the acutely ill in Montana. Eliminate certificate of need restrictions for acute care facilities and providers in our State.


Hollis K. Lefever, M. D.

Signatures of Concurrence:


Administrator, Central Montana Hospital

Medical Staff - Central Montana Hospital



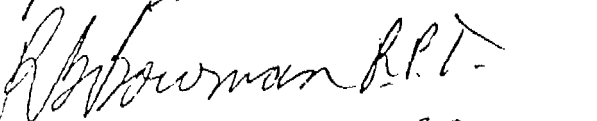
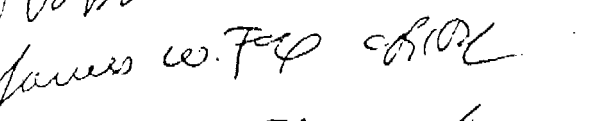
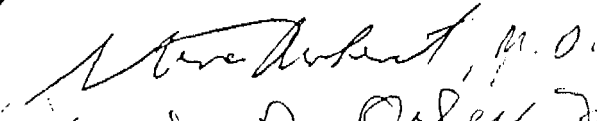






EXHIBIT 3
DATE 3-3-89

HOUSE HUMAN SERVICES AND AGING COMMITTEE

During the 1989 session, you will be dealing with legislation concerning Certificate of Need (CON). The legislation concerning CON will range from maintaining its current structure to letting it sunset. It is my belief as a rural hospital administrator, who has been involved with three (3) building projects since 1976, to let it sunset. It is my belief that the current legislation regarding CON is time consuming, costly and can be restrictive. It is my intent to share with you my thoughts about the CON.

First, let me review the process we, as healthcare administrators, must go through for a building project or major remodeling process.

- 1) Internal Planning
 - a) list problems and ideas
 - b) develop solutions
- 2) Hire professional planners or architects
- 3) Present plans and ideas to local community
- 4) Secure funding and local support
- 5) Hire professionals to develop CON application
- 6) Submit to CON Board and request hearing date
- 7) Present application to CON Board
- 8) If there is no contention - start project

If there is contention or questions, this can be for a variety of reasons, i.e., local study differs from state plan which uses averages, or there may be political roadblocks. The CON application process starts over.

- 1) Application is redone or revised
- 2) Re-submitted to CON Board
- 3) Re-schedule hearing with CON Board
- 4) Present application to CON Board
- 5) If no contention - start project.

EXHIBIT 4
DATE 3-3-89
HB 340

In my experiences, the CON application has been an unnecessary burden which does not assure quality as an outcome. I would like to recap each briefly.

- 1) Nebraska. Project to decrease hospital bed size, increase emergency room facilities and remodel obstetrics, surgery and physical therapy.

Questions were raised if we had done sufficient planning and did the community support the project.

RESULT - delayed project by six (6) months and created additional cost. On second hearing, four hundred (400) people traveled to hearing to demonstrate their support, community of 3,000 people. Project had also been approved prior to first CON hearing by a vote of 78%.

- 2) Wyoming. Project to increase number of nursing home beds and downsize hospital by six (6) beds.

Questions were raised regarding local statistics, did not coincide with state averages.

RESULT - project delayed, statistics had to be re-verified and re-submitted. Again, we had additional cost added to project. Problem was local statistics for elderly over 65 were higher than state averages and there was disbelief on the waiting list submitted. Project was approved on second hearing.

- 3) Wyoming. Project to joint venture with medical staff.

Question was raised if the hospital and physicians could work together in this arrangement, and if the project was really necessary to provide healthcare in a rural setting.

RESULT - project delayed, additional costs were added to project. Project approved on second hearing.

Prior to both Wyoming projects, hospital and physicians held open forums in the community (prior to hearings). Projects were voted on through the 1% sales tax levied to complete the projects. Vote was 70 plus percent in favor of the projects.

EXHIBIT 4
DATE 3-3-83
PAGE 34

In each case, we had approval by the local community to support and fund projects and there was no outside contention with our projects; however, each project experienced a delay due to the CON process.

The problem that I have experienced with CON are:

- 1) It is costly - as a result the costs associated with this process are shifted to the consumer in the end.
- 2) It creates delays - the delays in effect are costly and in some cases the quality (suffers).
- 3) There are political problems that arise from the process.
- 4) I believe free enterprise is restricted.
- 5) Monopolies are created by legislation.
- 6) If CON is the answer to controlling healthcare, why are so many states battling the issue and sunseting the law.

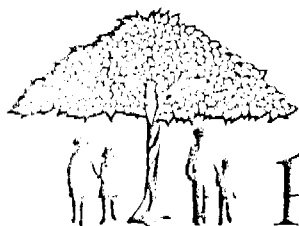
When one becomes involved in a building process, the CON process becomes another obstacle to cross. It is not spoken of favorably unless it is restricting a competitor.

If the intent of CON is to assure quality, it has missed the boat. If it is to restrict the access of healthcare and limit the technologies associated with building or remodeling, then it is working. One last point, if CON is an asset, why haven't other industries introduced this type of restrictive legislation?

In conclusion, I support Senate Bill 340 (The Williams Compromise) and I am opposed to Senate Bill 217.


Jerry E. Jurena
Administrator/CEO
Trinity Hospital
Wolf Point, Montana

EXHIBIT 24
DATE 3-3-89
HB 340



Providence
Specialists in Family Counseling for
Chemical Abuse and Addiction Management



PHONE (406) 727-2512
1-800-367-2511

Providence
Specialists in Family Counseling for
Chemical Abuse and Dependency
SANDRA ERICKSON
DIRECTOR OF MANAGEMENT SERVICES
401 THIRD AVENUE NORTH • GREAT FALLS, MT 59401
CUT BANK, MT • CONRAD, MT

HUMAN SERVICE AND AGING COMMITTEE

March 3, 1989

Proponent For SB340 *with amendments*

I am here today representing Providence, a family counseling center specializing in chemical abuse and dependency, located in Great Falls. We are a private, nonprofit agency and have been in existence for over twenty years. We have facilities in three counties: Pondera, Glacier, and Cascade.

I am also testifying for Chemical Dependency Programs of Montana, an association of 23 member programs from throughout the state.

I, as an individual program and CDPM are proponents of SB340 because it is the only certificate of need legislation left alive.

Inpatient chemical dependency treatment facilities are required to function within the regulations of CON to maintain an orderly growth in our rapidly expanding industry, there is a reason. Nationwide an inpatient chemical dependency treatment center opens every three weeks, primarily in hospitals to offset losses in acute care services. Montana, however has wisely charged the Department of Institutions to assess each county's needs every four years to carefully prepare a comprehensive chemical dependency plan. That comprehensive chemical dependency plan has three objectives:

PRACTICE INCLUDING BUT
NOT LIMITED TO:

- Assessment & Referral
- Interventions
- Intensive Outpatient Program
- Individual and Group Therapy
- Family Therapy
- Adolescent and Children Services
- Prevention and Education
- ACI Program
(Providence Court School)

EXHIBIT

- 1) To assist the citizens of Montana in understanding the problems of chemical dependency and efforts currently employed to deal with this problem.
- 2) To provide a policy document that promotes efficiency, cost effectiveness, and availability of chemical dependency services within the state.
- 3) To provide information to service providers, other agencies involved with chemical dependency services, state and local government agencies, and the Montana Legislature about the current status and future requirements of chemical dependency programming.

Please note that last sentence: future requirements of chemical dependency programming. This comprehensive planning document and the CON process guide Montana in development and growth based on the documented need of those services. Montana treatment facilities have witnessed unbridled growth in neighboring states, Utah and Minnesota immediately come to mind, that have ultimately resulted in reduced quality of care, reduced occupancy rates, reduced treatment options and left the field of chemical dependency treatment in shambles.

Thankyou and I urge you to pass SB340

*I am concerned with the expansion of existing services
as well as expansion of new services*

EXHIBIT 5
DATE 3-3-89
HB 340

MONTANA ASSOCIATED PHYSICIANS

1242 North 28th Street
Billings, Montana 59101
406-248-1635
1-800-648-MAPI (6274)

POINT SHEET

1. Montana Associated Physicians, Inc. is an 87 member physician organization based in Billings. (Our practices employ approximately 350 people in addition to our physicians.)
2. Eliminating this expensive, time-consuming and counter-productive Certificate of Need process for hospitals would improve access to medical technology for all physicians, including those in rural areas.
3. Referring physicians from the entire region, as well as their respective patients, should have a choice of services (hospitals).
4. The Federal Trade Commission actively promotes competition in health care. Certificate of Need law can hold the level of services below what the public needs, create a demand for these services and increase prices well beyond what they would have been in a competitive situation. Competition ensures that services will be offered at the lowest possible price, regardless of where the procedure is done.
5. The time has come to let hospitals control their own destiny. Hospital boards and administrators are in a much better position to determine what their communities need and what they can and cannot afford than some governing agency almost 400 miles away.
6. Health care is surely the dominant industry in the state, and considering the state of our economy, I think that we have no choice but to let this component of our economy grow and develop in any way that we can.
7. Because the health care industry, particularly the reimbursement systems, is in such a state of flux, the need for regulatory processes, such as Certificate of Need law, has to be re-evaluated on a regular basis.
8. In summary, Montana Associated Physicians, Inc. supports Senate Bill 340 without amendments.

EXHIBIT 5
DATE 3-3-89



Saint Vincent Hospital and Health Center

SAINT VINCENT HOSPITAL AND HEALTH CENTER
TESTIMONY OF JAMES T. PAQUETTE BEFORE
THE HOUSE HUMAN SERVICES AND AGING COMMITTEE
MARCH 3, 1989
CERTIFICATE OF NEED LEGISLATION

Chairman Hansen and respected members of this Committee, my name is James T. Paquette and I serve as President and Chief Executive Officer of Saint Vincent Hospital and Health Center, a 280-bed general acute care hospital in Billings, Montana. We have consistently taken a position against Certificate of Need law for hospitals since the changes in Medicare and Medicaid reimbursement went into effect in the mid 80's.

We support the elimination of Certificate of Need law as it relates to hospitals and as it is embodied in Senate Bill 340, without amendments. The Senate showed tremendous support for Senate Bill 340 through a vote of 49 to one, and we ask that the House concur.

Decades ago, Certificate of Need legislation was intended to function as a cost-containment device. When it was first enacted during the early 70's, there was little incentive for hospitals to control their costs. Medicare and Medicaid reimbursed on a cost plus basis, so the more they spent, the more they were reimbursed. With the introduction of the DRG (Diagnostic Related Group) system in the mid 80's, the situation changed dramatically. In this new era, decisions to enter into new services or purchase capital are based upon: 1) demand; 2) ability to command a price in the market sufficient to cover costs and provide margin for capital; 3) ability to deliver quality care. Certificate of Need law is no longer necessary to control costs or excess building.

Proponents suggest that eliminating CON for hospitals will increase Medicaid costs. They claim that hospital service costs are growing faster than any other segment of the Medicaid budget. This growth is not the result of hospitals' increasing their charges, as some proponents of the Certificate of Need process would like you to believe. Hospitals in Montana have been paid a fixed fee per Medicaid admission for inpatient services since October 1, 1987. No matter how much is charged, we are still reimbursed the same amount.

There is no evidence that the absence of Certificate of Need law contributes to higher cost to the patient. Montana ranks 47th out of 51 states (including the District of Columbia) in cost/admission according to data supplied by the Montana Hospital Association. We submit that this is not a result of any regulatory process. A more probable explanation is that hospitals representing 85% of the beds in this state open their rates to a voluntary review process. Last year average rate increases approved through this process were approximately 7%.

Post Office Box 35200
Billings, Montana 59107-5200
(406) 657-7000

We touch your life.

EXHIBIT 6
DATE 3-3-89
HB 340

Contrary to some of the stories you have heard, deregulation does not promote unwarranted growth. For example, Wyoming deregulated in May, 1987. At that time, 600 long-term care beds had already been approved under CON law. Since then, approximately 400 of those beds have either been completed or are still under construction. No other capital activity is anticipated for several years. Granted, Wyoming's economy doesn't allow for much activity. But, Wyoming's economy more closely parallels Montana than does Arizona and Utah. It is not valid to compare states with total populations of less than a million with large metropolitan areas of more than 3 million people. The growth rate in Arizona two years ago was almost four times the growth rate of the entire United States. These two states, of course, are cited by proponents of Certificate of Need law as examples where deregulation only fuels unnecessary construction.

The Federal Trade Commission (FTC) actively promotes competition in health care. The Commission has cited the entry barrier created by CON law as a factor significantly contributing to the potential for anti-trust violations.

Proponents of CON law suggest that joint ventures would not occur without a CON process. In Billings, Saint Vincent Hospital has entered into a number of cooperative ventures with Deaconess Medical Center and will continue to evaluate other opportunities. The two hospitals operate a jointly-owned hospice, cancer center, MRI unit and laundry services. These joint ventures were sound business decisions based on months of research and planning. They were not a compromise for a contested CON application.

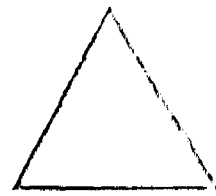
Senate Bill 340 is a compromise bill. It recognizes the needs of nursing homes, psych hospitals, rehab hospitals, mental health and chemical dependency programs and allows these types of services to remain under the protection of Certificate of Need law.

In summary, we support Senate Bill 340 and ask that the House concur for the following reasons:

1. There is no proof that CON law reduces costs to the consumer.
2. There is supporting documentation that CON legislation raises costs of operation to hospitals.
3. CON law is a clear restraint of trade and hinders the ability of hospitals to function in the free marketplace.

EXHIBIT 6
DATE 3-3-89

MONTANA
HEALTH
CARE
ASSOCIATION



36 South Last Chance Gulch, Suite A
Helena, Montana 59601
406-443-2876

Senate Bill No. 340 - Certificate of Need

PROPOSED AMENDMENT

Amend Senate Bill 340 as follows:

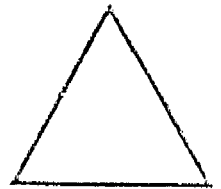
1. Page 4, following line 15, add a new section (3):

"(3) For purposes of subsection (1) (i), the provision by a hospital of services for ambulatory surgical care, home health care, long term care, inpatient mental health care, inpatient chemical dependency treatment, inpatient rehabilitation, or personal care, includes all activities described in subsections (1) (a) through (1) (h) related to the provision of the enumerated services."

2. Renumber subsequent sections.

Explanation:

This amendment is required to clarify that any activity undertaken by a hospital related to providing long term care and the other services enumerated in section (1) (i) such as adding new beds by construction, expansion or conversion, will require a certificate of need. If another provider, such as a nursing home or chemical dependency treatment facility, would be required to obtain a CON in order to engage in the activity, then a hospital would be treated similarly.



SENATE BILL 340

PROPOSED AMENDMENT TO INCLUDE HOSPITALS IN CERTIFICATE OF NEED
PROCESS

Amend Senate Bill 340, as follows:

1. Page 3, line 25, following "or"
Insert: "or"
2. Page 4, line 5, following "50-5-101"
Strike: "; or"
Insert: "."
3. Page 4, lines 6 through 9,
Strike: in their entirety.
4. Page 4, line 20, following "hospital,"
Insert: "hospital,"
5. Pages 4, lines 24 and 25, and page 5, line 1,
Strike: in their entirety.

Explanation:

The amendments remove the hospital exemption and make hospitals and all health care providers currently covered by certificate of need a part of the CON process.

The legislation continues to include a two-year sunset for review of the process.

The amendments are necessary to avoid an unconstitutional distinction between hospitals and other health care providers and to maintain some method of controlling hospital costs and duplication of services and equipment.

MONTANA HEALTH CARE ASSOCIATION



36 South Last Chance Gulch, Suite A
Helena, Montana 59601
406-443-2576

SENATE BILL 340 - Exempting hospitals from
Certificate of Need

THE HIGH COST OF DEREGULATION...

The Montana Hospital Association's "green sheet" indicates that no study has been released that claims that certificate of need reduces health care costs.

The fact is that studies are available with respect to the states of Arizona and Utah--which have been without CON longer than other states--which indicate that unnecessary services--both hospital and nursing home--have proliferated; that occupancy rates have gone down; and that total health care expenditures have gone up, when CON has been abandoned.

Common sense should tell us all, including the Hospital Association, that when services are duplicated and occupancy goes down, costs go up...and the consumers and taxpayers pay the bill.

The attached newspaper articles should be of interest in that regard.

The "free enterprise" system you're being asked to experiment with is funded with state and federal taxpayer dollars coming from the Medicaid and Medicare programs.

PLEASE SUPPORT SENATE BILL 340 WITH AMENDMENTS TO INCLUDE HOSPITALS IN THE PROCESS.

EXHIBIT 7
DATE 3-3-82
HB 340

Opinion

The Billings Gazette is dedicated to Billings and Montana where the quality of life must be maintained.

Keep hospital costs low

The state Senate recently passed Senate Bill 340 with an overwhelming 49-to-1 vote. The bill is now resting comfortably in the House Human Services Committee awaiting a hearing.

GAZETTE OPINION

The measure would allow the expiration of a law requiring hospitals to obtain a "certificate

of need" from the state before hospitals could proceed with new services or an expansion of existing services. Essentially, the certificate-of-need law is intended to eliminate duplication of services and, presumably, keep health-care costs down.

In Billings, Deaconess Medical Center officials took one look at the Senate vote, considered the odds and withdrew from administrative hearings reconsidering St. Vincent Hospital's proposal to add cardiac surgery to its services.

If indeed SB 340 is a *fait accompli*, then we can safely assume that not only will St. Vincent add cardiac surgery to its list of services, but those hospitals in the state that are in direct competition with each other will — to one degree or another — engage in games of one-upmanship with programs, services and equipment.

Health care in America today is a very expensive business. Monday's Wall Street Journal reports that

hospitals in some parts of the country are paying kickbacks to doctors who refer patients to them. Any way you look at it, that unethical practice is just another hidden cost that must be borne by the health-care consumer.

The certificate-of-need law served as a check and balance against costs.

Without it, both Deaconess and St. Vincent have an obligation to keep the high cost of medicine down and the quality of care up. Patients must insist on that.

Applause due

The Yellowstone County Commission held its brainstorming session last week and opened it to the public. That was after Commission Chairman Dwight MacKay's uncertainty over inviting the public.

MacKay and the other commissioners deserve an A-plus not only for allowing the public in but also for developing a mission statement and outlining goals.

The statement is clear and uncomplicated, and the goals intelligent and necessary. We now know how much the commissioners are dedicated toward improving government, and that helps all of us.

Commentary

Laissez faire sends nursing home tab to public

By William Lambdin

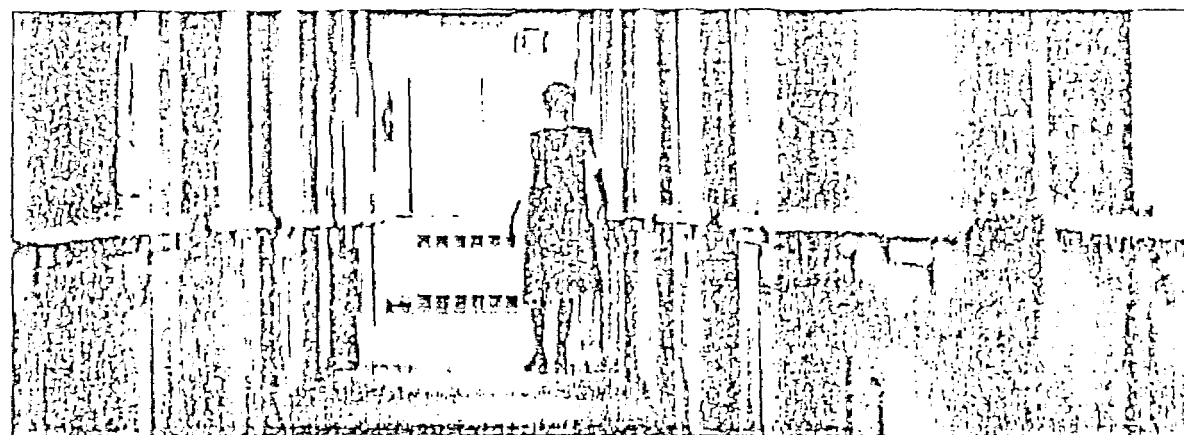
COLORADO could see dramatic increases in nursing home costs if the state legislature deregulates the health-care industry and allows too many nursing homes to be built. Costs to patients and taxpayers could go up needlessly. Quality of care could go down. Just ask Arizona.

The Arizona legislature deregulated nursing homes in 1982. Since then the state has seen a 76% increase in the number of nursing home beds. State Medicaid expenditures have increased by 54% at taxpayers' expense. Nursing homes struggling to survive because of intense competition have cut staff, food service and other things that lower the quality of care. Arizona Health Department official Marlene Mariani said the state has become "a perfect example of the proliferation of services that will occur when there is a lack of controls."

The few other states that have eliminated controls have had similar problems. Texas had to place a moratorium on Medicaid payments to stop rapid expansion of nursing homes. Utah has seen huge increases in nursing home construction in the last three years. California is reinstating controls after eliminating them just two years ago.

Colorado's Certificate of Need law that regulates nursing-home expansion will expire this July. If it is not replaced by other controls, several of the big, national health-care chains will expand here just as they did in Arizona. They don't care if too many nursing homes are built. They have millions to invest and figure they can outlast local competitors. Half-empty facilities don't bother them. Through investment tax breaks and other advantages, they have learned how to manipulate the health-care system, skimp on care and end up with a profit. The usual marketplace forces of competition don't apply.

Charles Froelicher knows that. He is a



LIBRARY FILE PHOTO BY THOMAS H. BROWN

Regulations governing the expansion of nursing homes in Colorado expire in July unless the legislature reviews them.

member of Colorado's Health Data Commission that collects information on health-care operations throughout the state. He recently said, "Without question, marketplace forces are not at work in the health-care system." He charges that large corporations are able to create monopolies, increasing rates and making huge profits while treating fewer patients.

How do you make more money if you have fewer patients? You charge each patient more. How can you justify that? Because you have "fixed costs" that must be paid regardless of the number of patients.

Nancy McMahon with the Colorado Health Department explained how this Catch-22 works: A nursing home's costs for building maintenance, mortgage payments and equipment remain the same and must be paid whether it is full or half empty. As the number of patients drops, the cost per patient rises to meet the fixed costs.

The kicker is that most of those higher per-patient costs are passed on to the state through Medicaid increases. As a tax-sup-

ported program, Medicaid pays nearly 70% of all the health care given in nursing homes. It is mainly for poor people or the chronically ill who cannot obtain insurance. Increases in their nursing home bills can cost the state plenty.

A few state legislators realize this. Sen. James Beatty, R-Fort Collins, is sponsoring legislation to continue state controls on nursing homes. He is supported by the Colorado Health Care Association, which represents most of the state's current long-term care providers. CHCA director Arlene Linton says figures show that Colorado doesn't need any more nursing homes. Medicaid admissions are now 200 fewer per month than four years ago. Overall occupancy is down about 1,000 patients. A recent U.S. General Accounting Office report also says that nursing home occupancy rates are declining nationwide.

Beatty's bill may face heavy opposition from health care corporations that want to expand. Their lobby is strong, and deregulation is popular these days. We have de-

regulated the airlines, banks and other industries. Legislators will be tempted to go along with the trend.

Maybe hospitals and some health-care operations should be deregulated. But not nursing homes at this time. Marketplace forces that encourage improvements through competition are lacking. The experience of other states shows what will happen.

There is one other thing we should remember: The basic principle of all health care is that the public ultimately pays for it — through higher medical bills, increased insurance premiums or more taxes. If you see health care facilities going up on every corner like filling stations, don't wonder who pays for them when they are nearly empty. You are paying for them.

William Lambdin, Greeley, is author of "Doublespeak Dictionary" and publisher of "Senior Voice," a news magazine for retired people in Colorado and Wyoming.

7
3-3-89
340

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Journal
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50 CENTS

Warm Bodies

Hospitals That Need Patients Pay Bounties For Doctors' Referrals

The Practice Is Questionable,
But It Spreads as Profit
From Care Is Threatened

Lack of Enough Sick People

By WALT BOGDANICH
And MICHAEL WALDHOLZ

Staff Reporters of THE WALL STREET JOURNAL

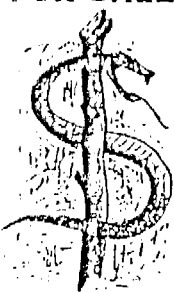
The hottest commodities in the patient-care business these days are patients. Hospitals with empty beds and testing centers with idle equipment are buying. Doctors are selling.

Patients are rarely aware of the under-the-counter market in their bodies. Many physicians are acutely aware of it; some profit and see nothing wrong with it. "I can admit [a patient] to any hospital that I want to for any reason I want," physician David Spinks testified at the 1986 kickback trial of a Texas hospital administrator. "I don't have to justify that to anybody. I can admit . . . because I don't like the color of the carpet [at a competing hospital,] or I don't like my parking spot."

At issue in the trial, however, was the \$70 per patient that Pasadena General Hospital was paying Dr. Spinks as a consulting fee whenever he referred a patient to the hospital. The hospital paid in order to keep Dr. Spinks from sending his patients to other hospitals.

Reporters for The Wall Street Journal spent three months examining the buying and selling of patients. The practice

PATIENTS
FOR SALE



FIRST OF A SERIES

of paying kickbacks is widespread and growing, stimulated by public and private efforts to contain the costs of medical care. The efforts have worked to keep some patients out of hospitals and shorten the stays of others. In either case, the result is empty beds in hospitals; the occupancy rate has dropped by 14% in a decade.

"We don't have enough sick people to go around," says Linda Quirk, a health planning official in Miami. "That's good news for patients, but not so good for hospital profits."

Physicians have become more vulnerable to financial inducements offered by hospitals and testing centers because the physicians' income is under pressure, too. "Doctors no longer have a blank check to essentially set whatever price they want, and make as much money as they think is reasonable," says Barry Moore, of Hamilton/KSA, a medical consulting group in Atlanta.

Paying for patients helps keep health-care costs up and encourages unnecessary medical services. A Rhode Island physician, Felix M. Balasco, sent 29 people to the hospital for pacemaker implants they didn't need; for taking kickbacks he was convicted in federal court in Providence of Medicare fraud in 1986.

The practice sometimes denies patients higher quality care that they might have received at another hospital. One hospital accused in a physician kickback scheme is Medical Center of North Hollywood, in California, operated by the American Medical International chain. U.S. Health Care Financing Agency reports show that in 1986, this hospital was one of only 2.4% in the nation whose Medicare patients died at a higher-than-predicted rate. The hospital, however, in a letter to federal health officials, says it provides excellent care. The hospital also says its patients are sicker than those in other hospitals.

Of even broader concern, many health-care specialists say, is the new willingness of reputable hospitals—large and small, for-profit and nonprofit—to push ethical boundaries in their search for patients.

There is little doubt that the practice of selling patients is worsening.

Last year, the U.S. attorney in Philadelphia charged nearly 400 area physicians with taking kickbacks to send patients to a medical testing laboratory. It is believed to be the largest single enforcement action ever brought against physicians. This in part prompted Richard Kusserow, deputy assistant secretary for general of the Department of Health and Human Services, to warn of a "nation-wide proliferation" of kickback allegations in medical testing.

Donald S. Winston, a Houston physician, says kickbacks have been so common at times that American Medical International, the hospital chain, once mistakenly sent him a \$50,000 check intended for another physician. The check was delivered some years ago by a bank officer. "I grabbed it out of her hand, locked her in the waiting room, copied both sides, then returned it," Dr. Winston says.

Angry over seeing that check, Dr. Winston filed suit against American Medical International, Twelve Oaks Hospital in federal court in Houston. The suit alleges that American Medical secretly paid \$1 million to subsidize a physicians' group in return for their patients. Twelve Oaks used the money to persuade physicians to refer patients to "higher cost hospital services" rather than lower cost out-patient services, according to briefs Dr. Winston filed in court in 1987.

Officials of American Medical declined to be interviewed because the case is pending. In court papers, American Medical doesn't deny making payments to physicians, including Dr. Winston, but says it

Please Turn to Page A8, Column 1

EX-107 7

DATE 3-3-89

HR

240

Warm Bodies: Hospitals That Need Patients Pay Bounties to Physicians in Return for Referring Them

Continued From First Page

was merely following a legal, industry-wide practice of helping physicians build a patient base near hospitals. American Medical says it requires only that physicians who receive payments obtain hospital staff privileges so that they have "the option" of referring patients to Twelve Oaks.

American Medical, however, did admit recently in court filings in California that it is a target of a federal criminal investigation in connection with payments to physicians.

In a lawsuit filed last year in a California state court, Maxicare Health Plans Inc., a health-maintenance organization, accused American Medical of paying \$1.2 million to buy patient referrals from a physicians' group, Hawthorne Community Medical Group. Maxicare calls the payments illegal kickbacks, and says they raised medical costs for its patient-members treated at American Medical hospitals.

Maxicare alleges that the chain disguised the payments as financing for office locations for the physicians' group and as consulting fees to the group for reviewing patient care at three of the chain's Los Angeles area hospitals. American Medical, in court papers, has denied any wrongdoing. The Hawthorne group declines to comment.

Patients rarely can count on government to protect them from exploitation. State and federal anti-kickback laws are weak or rarely enforced. Federal law does forbid even indirect kickbacks for referring Medicare and Medicaid patients to hospitals or testing centers. But federal prosecutors say they can't recall a single successful prosecution of a hospital for patient buying. Many states don't specifically forbid hospitals from paying kickbacks to physicians.

Medical ethics, as defined by the American Medical Association, prohibit direct kickbacks. But the ethical code fails to address the many indirect kickback schemes that are employed. Nor do ethics address the lucrative ownership interests in testing centers being offered to physicians who can effectively guarantee profits by referring patients to the centers.

The situation at Pasadena General Hospital in 1985 was critical. Operating in a grimy Houston suburb, the aging hospital had been financially hemorrhaging ever since it was purchased in 1983 by American Healthcare Management Inc., a publicly traded owner and operator of hospitals.

The reason was simple: Physicians had suddenly stopped sending their patients. If Pasadena General were to stop the bleeding, it somehow had to change the minds of those physicians.

By 1985, the hospital had such a plan. Straying physicians would be offered a potpourri of financial incentives: profits from a sophisticated X-ray machine but none of the risk; paid committee appointments requiring little work; the possibility of free

"MESHANE" OK.

"FURTH: I'm not rushing you. . . I know you can't predict what may be happening next week, but if— if you have some admissions around Tuesday evening. . ."

Mr. Furth later explained in testimony that high occupancy would put his boss "in a very, very good mood."

The Fall Guy?

Rick Robinson, a Washington lawyer for American Healthcare and Pasadena General, says: "The company's view was that they didn't approve of any agreement to pay physicians for referrals. And such an agreement, had it existed, would have violated company policy." But Randy Schaffer, a lawyer who represented Mr. Furth, blames American Healthcare for his client's problems.

"He went out and recruited in the manner they suggested, then when it all bit the fan, [they] let him take the fall," Mr. Schaffer says. "They couldn't single my guy out of all the people in the country and make him a felon, because that's the way the industry operated."

Mr. Furth's prosecutor, Linda Lattimore, agrees that Mr. Furth "was just doing what was common in the trade. That's my gut feeling, really."

That's certainly what Mr. Furth thought. "Let's say something should happen to me," said Mr. Furth in one of Dr. McShane's tape recordings. "You also want to know that the next person coming in is going to be doing the same damn thing I'm doing."

Just days before Mr. Furth spoke of patient buying in front of Dr. McShane's hidden microphone in Texas in 1985, a similar conversation was taking place more than 1,200 miles away, in a quiet Midwestern town just off the Lake Erie shore.

On a July evening, board members of the nonprofit, tax-exempt Northeastern Ohio General Hospital were meeting in the hospital's community room to act on a gamble to bring in more patients. The plan was for the small, revenue-poor hospital to lend \$75,000 to a group of six physicians, the core members of the independent Madison Clinic.

This was to be a special loan: It didn't have to be repaid. All the physicians had to do to get it was promise to admit "not less than 75% of their patients."

One reason for the generosity: In the previous four months Bill Stoerckel, a Madison Clinic physician, had referred less than half the number of patients than he had referred during the comparable months the year before. The hospital couldn't afford such patient losses.

At a board meeting several months earlier, Dr. Stoerckel, representing the clinic, had warned the hospital to talk money quickly if it wished to compete with other hospitals for patients from the clinic.

Conscience and Cash

"Dr. Stoerckel stated that he has walked the halls for a lot of years and it seems as though to get some financial help makes one feel better that the Board is standing behind you," according to hospital board minutes.

make, president of Jackson & Coker, a national medical consulting firm. He cautions that this might be illegal. It's "really on the leading edge," and "it's not widespread," Mr. Dismuke says.

More commonly, hospitals simply buy physicians' practices. A 1988 survey of 689 hospitals by Hamilton/KSA, a medical consulting firm, found that 18% were buying physician practices and another 8% were considering it. In some communities, "if you have locked in that supply of patients, then you have assured your future and you have significantly damaged your competing hospital," says Barry Moore, of Hamilton/KSA.

New Rules Sought

Still, says Mr. Kusserow, the Health and Human Services Inspector general "The physician's patients, in most cases may be totally unaware that the physician has sold his or her practice to the hospital."

Many of the purchases would be illegal under rules proposed by Mr. Kusserow. Congress requested the rules in hope better defining what it views as an overbroad and kickback law. These rules, currently undergoing a period of public comment, could take effect this spring.

More definitive federal law, however, won't eliminate the buying and selling of patients. Because so many state laws are weak, hospitals can avoid prosecution by buying only private patients.

Minnesota authorities, for example, have taken no action against the nonprofit Methodist Hospital in Minneapolis for paying a \$2.5 million kickback to the area's largest physicians' group, Park Nicollet Medical Center.

For this kind of money, Methodist Hospital wanted no Band-Aid-and-asp cases. Its December, 1986 contract with medical center stipulated that the hospital get 90% of those Park Nicollet patients requiring CT, or computerized tomography scans; radiation therapy; home care; patient rehabilitation; and selective outpatient surgical procedures. Medicare Medicaid patients were specifically excluded.

Uninformed Patients

The clinic was obliged to send patients over a period of three to five years.

The Hennepin County Medical Society calls the arrangement unethical. But Minnesota Board of Medical Examiners which licenses physicians, has refused to say whether it has even investigated the contract. The Minnesota attorney general's office says hospitals can't be held financially liable for paying kickbacks to get patients.

The county medical society condemns the deal on two grounds: Patients shouldn't be swapped for financial considerations, and patients should have a full understanding of the deal but weren't, says the medical society's Bruce Norback.

James Reinertsen, Park Nicollet's president, says he found Methodist's request for a patient "quota" "unfair" but went along with it because the quality of care wouldn't suffer. He says his clinic lost out on the right to terminate the contract without penalty if it alone decided quality anything less than the best available.

Ferry Finzen, Methodist's president, says increasing competition forced his hospital to protect its investments. "We're vulnerable," he says.

resigned in 1986, the company's president, General's administrator, Russell Furth, on charges that he violated a federal anti-kickback law.

Although Mr. Furth was acquitted at a 1986 trial, it wasn't because he didn't pay kickbacks; he admits to that. It was just that prosecutors couldn't prove he paid them to get Medicare patients. The trial provided a rare inside look at the seamy side of hospital competition.

Piece: \$70 a Head

Two flamboyant Houston physicians, Dr. Spinks and Jerry McShane, were central figures. Still in their 30s, they earned about \$400,000 a year each. Dr. Spinks drove a Porsche; Dr. McShane, a Jaguar. They jointly owned a rock-and-roll club, a weight reduction center, a horse breeding company, and the entity Pasadena General valued most: a thriving clinic.

Drs. Spinks and McShane had been steering almost all their patients to hospitals that directly competed with Pasadena General. Because Drs. Spinks and McShane were such valued prospects, one of Mr. Furth's first acts as Pasadena General's new administrator was to persuade them to switch their referrals. Although there is a disagreement over who breached the subject of kickbacks, each side ultimately agreed on a price: \$70 per patient, to be disguised as consulting fees.

Both Drs. McShane and Spinks testified that Pasadena General's previous owners had given them money. "Once a month this check would come, and if you tried to find out much about this check, you couldn't get much information," says Dr. McShane. He says the administrator would only say that it was for "supporting our hospital."

About the time that American Healthcare Management bought Pasadena General, the checks stopped coming. And Drs. McShane and Spinks began referring their patients to other hospitals. To reopen the patient spigot, Mr. Furth testified, his superiors at American Healthcare approved paying kickbacks, so long as they didn't involve Medicare or Medicaid patients.

A Grant of Immunity

Mr. Furth testified that he felt kickbacks in any form were wrong. But he said the company assured him that under Texas law he couldn't be prosecuted for such payments.

Under the state law, however, the physicians could under certain circumstances lose their medical licenses for accepting cash kickbacks. So when Drs. McShane and Spinks say they learned that selling patients might be improper, they sought and obtained immunity from state and federal prosecution in exchange for their testimony against Mr. Furth.

At the government's request, Dr. McShane secretly tape-recorded the administrator. On one tape, Mr. Furth shows his apprehension over the possibility that his company's president would find empty hospital beds during an upcoming visit to Pasadena General.

"FURTH: Next week the president of our Company is in. Will be here on Wednesday.

hospital board, whenever they can appear with other things he had heard. According to the board minutes, Dr. Chapman "related a conversation in which Dr. Stoerkel stated he could not admit patients to (Northeastern Ohio General Hospital) in good conscience due to substandard conditions and incompetence."

The hospital did have failings. According to 1987 hospital records, physicians worried about poor lab work and nursing errors, while a private inspection agency found that the hospital hadn't enacted an overall quality assurance plan.

The board decided to investigate the loan plan further, and on this July evening it met to take a final vote. Over Dr. Chapman's objections that buying patients might be illegal, the board voted to execute the agreement, which covered patient referrals until August 1990.

Physician's Explanation

The "loan" agreement didn't specifically exclude Medicare and Medicaid patient referrals, although it is a felony under federal law to knowingly solicit or receive a kickback in exchange for Medicare or Medicaid patient referrals.

Dr. Stoerkel confirms that he sent Medicare patients to the hospital after the clinic got its \$75,000. "I don't differentiate one patient from another," he says. But he says he doesn't believe he violated any law. "Most hospitals have arrangements with physicians, one way or another, where they are paying to keep them interested in using their hospital facilities," he says. He also says he never sent patients to the hospital unless they needed hospitalization.

The \$75,000 "loan" to the Madison Clinic physicians created problems for the hospital. Other physicians asked for similar payments. In 1986, for example, two other physicians asked the board for a "\$30,000 forgiveness loan similar to the Madison Clinic loan," according to hospital board minutes. The loan was granted.

Despite the hospital's attempt to buy physicians' loyalty, it closed three months ago. "The hospital was like the Shah of Iran," says Dr. Chapman. "He bought his power but eventually ran out of money. Here, people were saying give me \$75,000, give me this, give me that, until we too ran out of money."

The word "kickback" isn't fashionable among hospital administrators. They refer instead to "physician practice enhancement" and "physician bonding."

Some enhancement or bonding seems no more malign than ordinary business entertainment. In 1986, Sheridan Park Hospital, near Buffalo, N.Y., offered physicians who admitted 10 or more patients a month a "choice of dinner for two or one round of golf at the Country Club of Buffalo." Sheridan Park has since closed.

Leasing hospital beds to physicians who can, in effect, rent out the beds to patients at a profit seems more questionable. "Let's suppose I lease that bed [to a doctor] for \$700, and he is able to bill \$800 for that bed, then the doctor picks up \$100 for every patient he has," says Bill J. Dils-

Sidney Wolfe, who heads the consumer-oriented Health Research Group, says hospitals and physicians should get out of the business of buying and selling patients. "Is the purpose first and foremost to deliver the best patient care, or is it to use patients and their health problems as a front for making a lot of money?" Dr. Wolfe asks.

He adds: "If doctors and hospitals are going to act like racketeers, they are going to deserve to be treated like racketeers."

House bill would restrict hospital construction

By Merit C. Kimball

HealthWeek Washington Bureau

WASHINGTON—Rep. Fortney "Pete" Stark, D-Calif., introduced a bill Sept. 7 that would force states to crack down on inefficient hospital spending for new buildings, expansions and purchases of expensive medical equipment.

Hospitals that don't get approval for such expenditures would forfeit Medicare payments to cover these capital costs.

In attempting to revitalize the states' certificate-of-need efforts, the bill also would require states to identify hospitals that should close because of low oc-

cupancy rates. However, the measure contains no penalty to force hospital closures.

A trial balloon

Although the bill is a trial balloon that won't be considered until next year at the earliest, its intent is to rein in Medicare's capital payments for major hospital purchases. These payments have risen 76 percent during the past five years, compared with a 17 percent increase in general inflation, according to Stark, chairman of the House Ways and Means Health Subcommittee.

Stark said Medicare's capital pay-

ments are projected to rise an average of 11 percent annually through 1993.

"These increases will occur while use of hospital facilities reaches ever-higher levels of inefficiency," he said in a statement. "Over one-third of the hospital beds in the nation which are staffed are standing idle every single day."

Stark added that each empty bed, by conservative estimates, costs \$40,000 a year, for a total \$14 billion in "wasted resources."

"It certainly does not cost the amount of money Stark is talking about," said

Continued on page 33

SEPTEMBER 12, 1988

HEALTHWEEK

Bill restricts some spending by hospitals

Continued from page 9

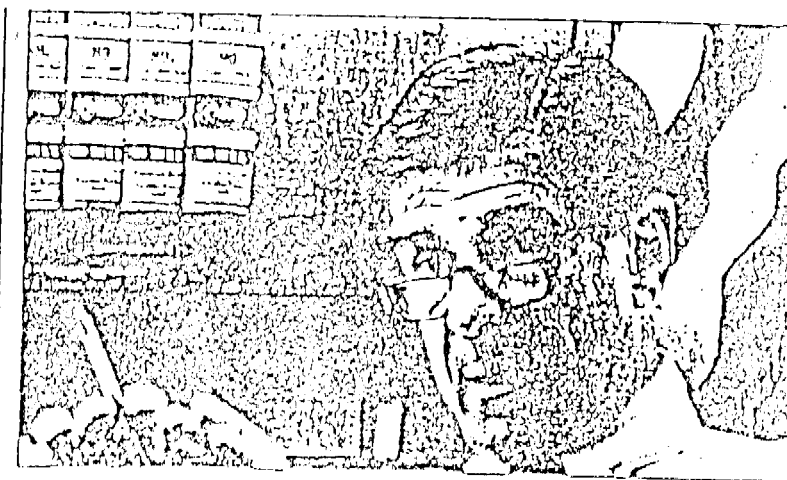
one health industry observer. The empty beds are "not staffed, not operated. No one is spending any money on them. They are stand-by capacity."

"A step back"

"This represents a step back into a certificate-of-need program that did nothing to eliminate excess capacity," said Jack Owen, head of the American Hospital Association's (AHA) office here. "We need to let economics dictate capital expenditures."

Stark said the "normal rules of economics do not appear to apply in any meaningful way to hospitals."

He said when Texas relaxed its capital-expenditure review law in 1985, nine new hospitals opened in Houston at a time when the city was in a recession due to falling oil prices. He added that \$1.5 billion currently is being spent on hospital construction there, even



Stark: Medicare capital payments expected to rise 11 percent annually.

though occupancy rates have declined to less than 60 percent.

Specifically, Stark's bill would:

- Require each state with an urban-hospital occupancy rate below 85 percent and a rural occupancy rate below 75 percent to set up a review system to approve any capital expenditure of more than \$1 million or which creates new beds or services. If the state does not set up this system, Medicare would withhold capital reimbursement.

According to AHA data, every state is below those oc-

cupancy rates.

- Limit the amount of new capital spending allowed per year in each state but still allow cost-based reimbursement within that limit.

- Exempt rural hospitals from the limits if the state develops a separate health plan to stabilize those hospitals.

Stark's bill has no chance of consideration this year before Congress adjourns in October. But next year, as one congressional aide put it, "Whatever saves money is a viable option—no matter how wild and crazy it may seem." □

EXPERT 7
DATE 3-3-89
HB 340

MONTANA HEALTH CARE ASSOCIATION



36 South Last Chance Gulch, Suite A
Helena, Montana 59601
406-443-2876

SENATE BILL 340 - exempting hospitals from
Certificate of Need

DEREGULATION - THE ARIZONA EXPERIENCE....

The following information is excerpted from a report on Arizona deregulation entitled, "A Study of the Impact of Health Care Deregulation on Hospitals, Nursing Homes, and Health Services in Arizona."

Nursing Homes:

	<u>1982</u>	<u>1985</u>	<u>%</u>
Beds	8,313	12,559	+51.1%
(Growth of 51.1% for 3 years, compared to 55.8% for preceding 9 years.)			
Occupancy	92.55	82.8	-10.5%
Gross patient revenues	\$124.2M	\$224.7M	+81 %
Per capita expenditures	\$370.76	\$553.81	+53.5%

"In Arizona, nursing home care is provided by the counties.
Increasing costs are placing a heavy cost burden on county funds."

Hospitals:

New hospitals	3	
Psychiatric hospitals	1	
Open Heart Surgery	5	.. the number of surgeries increase 18.2% per 100,000 population.
Cardiac Catheterization		
Labs	3	.. the use rate rose 13.1% per 100,000 population.

MRI systems: Arizona has 9 MRI systems. (Comparison: California with 10 times Arizona's population, has only 18 unit

The state estimated in the report that "consumers are currently expending in excess of \$225 million per year for excess hospital capacity."

A STUDY OF
THE IMPACT OF HEALTH CARE DEREGULATION
ON
HOSPITALS, NURSING HOMES AND HEALTH SERVICES
IN ARIZONA

November 15, 1985

Gloria Heller, Associate Director
Mary Chase, Planner

Office of Planning and Budget Development
Arizona Department of Health Services
1740 West Adams Street
Phoenix, Arizona 85007

DATE 7
3-3-89
HB 340

CONTENTS

I. History and Time Frames.....	1
II. Nursing Homes.....	2
III. Hospitals.....	5
IV. Health Services	9
V. Cost Impacts	10

NOTE

The data for this study were provided by the Office of Health Facilities and Economic Review, Arizona Department of Health Services. Within this Office grateful acknowledgement is extended to Fred Bodendorf, Ph.D., Manager, and to Cal Lockhart, Hal Webb, and Doris Evans of his staff.

EXHIBIT 7
DATE 3-3-89
HB 340

IMPACT OF HEALTH FACILITIES DEREGULATION IN ARIZONA

L. HISTORY AND DEREGULATION TIME FRAME

- A. Enactment - 1971: Arizona was one of the first few states to enact legislation authorizing Certificate of Need and Rate Review programs and Uniform Accounting and Reporting for Health Care Institutions. The Department of Health Services, established in 1974, received responsibility for the administration of these regulatory programs.
- B. Deregulation: The Arizona Legislature terminated Certificate of Need review for:
- Nursing Homes: July 15, 1982 (a 41-month period).
 - Hospitals: March 15, 1985 (an 8-month period). Deregulation included major capital construction projects, new services and high-cost specialty services affected by CON review criteria.
- C. Continued Regulation: Arizona's RR and UAR programs are still in place. The RR program requires mandatory participation of health care facilities and provides for voluntary compliance of the applicant with the State's review recommendations. Under RR and UAR programs, all health facility rates and charges are maintained by ADHS for public information and disclosure upon request.
- D. Current Status of Post-deregulation System Activity: Very dynamic, with activity in hospital and nursing home construction, bed expansion, freestanding and hospital-based outpatient facilities, tertiary services and rate increases.

II. NURSING HOMES

A. 1982 Status

1. Nursing Home Facilities: 79 Facilities
2. Beds (All Levels) 8,313 Beds
3. Average Occupancy Rate: 92.5% Occupancy
4. Beds/1,000 Population: 24.1 Beds/1,000 Pop. 65 + Years
5. Gross Patient Revenues: \$124.2 million
6. Per Capita Expenditures: \$360.76 - Pop. 65 + Years

B. Changes in Status: 1982 - Present

1. Permit Applications: A total of 169 nursing home applications have been received since deregulation in July, 1982:
26 in the last 6 months of 1982;
47 in 1983;
55 in 1984;
41 in 1985 to date
2. Number of Facilities: increased from 79 to 118 nursing home facilities, an increase of over 50% statewide in 3 years, with an average of 11 new facilities per year.
3. Number of Beds: increased from 8,313 beds in 1982 to 12,559 in 1985, an increase of 4,246 beds as of November, 1985. This is a 51.1% increase overall in 3 years, compared to a 55.8% growth in the preceding 9-year period 1974 through 1982.
4. Occupancy Rates: fell from 92.55 in 1982 to 82.8% in 1985, a decrease of 10.5% for the 3-year period.
5. Beds/1,000 Population 65 + Years: increased from 24.5 beds/1,000 to 31.3/1,000, an increase of 27.8% in the 3-year period.

When all proposed construction is completed, Arizona will increase to about 45 beds/1,000 elderly, an 84% increase over 1982. This ratio is approaching the national average of 50 beds/1,000 population; however,

75.3% of Arizona's beds are skilled nursing, compared to 20% nationally. Therefore Arizona's costs run significantly higher than other states for an equivalent number of beds.

6. Gross Patient Revenues: increased from \$124.2 million in 1982 to \$224.7 million in 1985, an increase of \$100.5 million (GPR) over 3 years an overall increase of 81%.
7. Per Capita Expenditures: The State's population 65 + years increased by about 17% from 1982-1985. During the same period, per capita nursing home expenditures increased by 53.5%, from \$360.76 (1982) to \$553.81 (1985).
8. Average Revenue Growth: increased by 22.0% per facility, compared with a 8.4% increase in the National Nursing Home CPI for the same period.
9. Average Arizona Rate Increase: stands at 5.6% for the 3-year period. This indicator is down from the 9-year average of 8.7% for the period 1974-1982 due to various market factors, including the surplus of beds and the fact that new facilities are establishing higher initial charges to support current building costs that average between \$25,000 and \$30,000 per bed.

C. 1985 Permit Activity (Year to Date)

1. Number of existing facilities: 118 Nursing Homes
2. Permit Applications Received: 41 applications
3. Permits Issued to Date: 7 permits
4. Profile of Proposed Construction/Expansion

New Facilities:	1,873 beds,	\$49.1 Million
Expansion of Existing Facilities:	308 beds,	\$9.2 Million
TOTAL	2,186 beds,	\$58.3 Million

EXHIBIT
DATE 3-3-89

5. Bed Redesignations: 355 beds were redesignated to a higher level of care:

- a. 147 Personal Care to Intermediate
- b. 208 Intermediate to Skilled Care

6. Nursing Home Care for Indigent Patients: In Arizona, nursing home care is provided by the counties. Increasing costs are placing a heavy cost burden on county funds. Although long-term care is not included under AHCCCS, the counties are increasingly using the AHCCCS model by employing a bid process which results in "below-market" cost levels for county patients. The industry's acceptance of this process is in part fostered by the existing surplus of beds and falling occupancy rates.

III. HOSPITALS

A. 1982 - 1985 Permit Activity

1. Hospital Facilities: 69 facilities in 1982 and 1983, 73 in 1984, and 72 hospitals in 1985. In the past two years, 4 mining hospitals closed and 6 new general hospitals opened, 3 of which were replacement facilities.
2. Permit Applications: A total of 366 permits received for the 4-year period; 86 in 1982, 106 in 1983, 78 in 1984 and 96 in 1985 to date.
3. CON Applications: A total of 39 permit applications were received for the 3-year period; 6 in 1982, 22 in 1983 and 11 in 1984. No CON applications were submitted to the State in 1985 in anticipation of the termination of CON on March 15.

B. 1985 System Performance Status (State Health Plan)

1. Hospitals by Type:

Total	88	Facilities
72 General Acute Nonfederal	10,762	Beds
16 Federal Hospitals	1,927	Beds
2. Growth in Nonfederal Bed Capacity: The statewide bed supply increased in the past 2 years by 833 beds, a 10% increase since 1983.
3. Population Growth/Admissions: Arizona's population grew 15% from 1980-1985. During the same period, hospital admissions increased only 5%, from 355,847 admissions in 1980 to 373,552 in 1984. The rate of admissions is therefore declining.
4. Average Daily Census: remained steady from 1980 (6,337 average inpatient census) to 1983 (6,367 average inpatient census). In 1984, the ADC decreased to an average ADC of 5,934, a decline of nearly 7%.
5. Total Patient Days: remained relatively steady from 1980 (2.36 million patient days) to 1980 (2.33 million patient days). In 1984, there were 2.17 million patient days, a decrease of 10% for the 12-month period.

6. Average Length of Stay: remained steady, averaging 6.4 days from 1980 through 1983, then decreased to 5.8 days for 1984.
7. Average Occupancy Rate: decreasing statewide. The 1984 rates are 60.1% in Maricopa County, 55.2% in Pima County, and 47.1% for all rural counties combined. The statewide occupancy rate for 1984 was 56.8%.

Only four acute care hospitals achieved the state standard of 80% occupancy for urban hospitals in the 3-year period 1982-1984. Overall occupancy in the existing hospital system has experienced a recent rapid decline.
8. Beds/1,000 Population: The State standard is 3.2 beds/1,000 population. The 1985 bed ratio currently is 3.7 beds/1,000.
9. Projected Bed Need: The 1985-1990 State Health Plan projects a statewide bed need of 7,827 acute care beds in 1990. Assuming there is no further expansion of the existing system, there will be a projected statewide excess capacity of 2,935 beds in 1990.
10. Estimated Cost of Excess Capacity: Based on the 5-year Consumer Price Index for Hospital and Other Medical Services, 1979-1983, the State estimates that consumers are currently expending in excess of \$225 million per year for excess hospital capacity.
11. Impact of DRG System: The Federal Prospective Payment System is clearly having an impact on hospital utilization in Arizona, but we do not yet have definitive data except for year-to-year measurements of system performance. Cost and revenue data and special analyses will be provided when a new computerized system is implemented.

C. 1985 Permit Status (8 Months)

1. Existing System: 72 Facilities, 10,762 Beds
2. Permit Applications: 96 total; 24 prior to termination of CON and 72 after termination.

EXHIBIT 7
DATE 3-3-89
HB 340

3. Total Permit Value: All projects - \$255,971,000.

4. Proposed New Facilities: 11 new hospitals

5. Permits Issued to Date: 1 permit (203 beds)

6. Profile of Proposed Hospital Construction:

New Facilities:	1,312	Beds	\$196.2 million
Existing Bed Expansion:	328	Beds	54.8 million
TOTAL	1,640	Beds	\$251.0 million

7. Change in Permit Status: 4 proposed new hospital construction projects totaling \$90 million were filed with the State immediately following termination of CON. These projects were withdrawn by the applicant several months later. The 4 projects included 3 new general acute care hospitals (500 beds), costing \$85 million, and 1 new psychiatric hospital (68 beds), costing \$5 million, all in the greater Phoenix area. These four projects were recently reinstated by the applicant.

8. Number of Projects Previously Subject to CON: If CON had remained in place, 38 (53%) of the 72 proposed projects filed after March 15, 1985 would have been subject to CON review. The total cost of these projects is \$164.75 million.

9. Bed Redesignations: A total of 90 beds have been redesignated as to use:

Med/Surg to SNF	30
SNF to Med/Surg	10
Detox to Med/Surg	2
Substance Abuse to Psych	30
Med/Surg to Pediatric	12

10. Other Activity:

a. There is a great deal of interest in Arizona by consultants nationwide for all kinds of health care projects.

- b. Hospitals are starting to compete in alternative health care settings by purchasing or establishing nursing homes, emergency/urgent care, home health, ambulatory surgery, outpatient clinics. There is evidence these facilities are increasingly used as "feeders" for referral of patients to inpatient hospital care. Some freestanding services competing with hospital-based programs (e.g., 25 home health agencies) have gone out of business in the past two years because they cannot maintain utilization.
- c. Some hospitals have purchased land in the outer peripheries of the greater Phoenix metropolitan area, as evidenced by zoning permits and HSA contacts.
- d. There is substantial interest by national health care chains in moving into the Arizona market, particularly Phoenix. However, there is interest in both hospitals and nursing homes in all areas of the State.

IV. HEALTH SERVICES

- A. Open Heart Surgery: 5 Permit Applications received, 4 Permits issued to date. The CONs for these projects were either previously denied, withdrawn or deferred until termination of CON. One project is costed at \$504,000; the remaining 4 applications indicate no cost since heart-lung machines were previously purchased and the project represents a new service not requiring construction. The addition of 5 new programs has reversed declining utilization: in 1984, HSA I had a 17.9% decline (117 surgeries/100,000 population). In 1985, surgeries increased by 18.2%, to 138.6/100,000. All of the increases came from units not approved under CON.
- B. Cardiac Catherization Laboratories: 3 Permit Applications received, 2 Permits issued to date. All CONs for this service had been denied in the past 2 years. In 1983, the statewide use rate was 239.5/100,000 population, and the national use rate was 218.8 procedures/100,000. In HSA I the use rate was 363.4/100,000, increasing by only 2.7% to 373.1 in 1984. After termination of CON, HSA I's rate rose to 421.8, a 13.1% increase. All increased were in units not approved under CON; procedures declined in some existing units which had received CON approval.
- C. Physical Plant Expansion: 9 Permit Applications received, 4 Permits issued to date for major expansion or renovation projects. Approximate cost: \$31.3 million.
- D. Nuclear Magnetic Resonance Imaging Systems: Arizona has 8 operating MRI units in both hospitals and freestanding settings. A 9th system is to be installed in the University of Arizona. Total cost exceeds \$14 million.
- Comparison - Utah has about 2/3 of Arizona's population, but only 3 units. California has 10 times Arizona's population, and had only 18 as of last summer.
- E. Lithotripsy Services: The lithotripsy service unit located in a Phoenix medical center serves as a statewide referral center. Two additional units are reported to be in the planning stages.

V. COST IMPACTS

- A. Hospital Rate Increase Proposals: As of October, 1985, 52 Rate Increase Applications were filed by Arizona hospitals since March, 1985, following a rate freeze in effect for 9 months. In addition, 4 hospitals that applied for rate increases in 1984 implemented the new rates during or after the freeze ending March, 1985.
- B. Hospital Revenues/Existing Rates: Prior to implementing these rate increases, existing rates for the 56 applicant hospitals generated annualized gross patient revenues of over \$1.82 billion. Total State gross patient revenues for all nonfederal hospitals exceeded \$2.02 billion in 1984. Total 1984 gross patient revenues for both hospitals and nursing homes in Arizona exceeded \$2.25 billion.
- C. Hospital Revenue Increases/Proposed Rates: The implementation of the proposed rate increases by the 56 applicant hospitals increased gross patient revenues for 1985 by \$109.4 million to a total of \$1.93 billion. This represented a statewide revenue increase of over 6%, as of October, 1985.
- D. Repeated Hospital Rate Requests in 12-Month Period: 2 private psychiatric hospitals implemented 2 rate increases in 1985 (both hospitals have the same ownership). The compound effect of the 2 rate increases raised revenues for these hospitals by \$1.02 million and \$999,000, increases of 13.0% and 11.4%, respectively, within a 10-month period.

The State Department has received applications for more than one rate increase within the year from several hospitals. In the last month, 6 hospitals within the State filed for a second rate increase in approximately 7 months. The compounding effect of double rate increases by these hospitals will result in the following revenue increases on an annualized basis:

Hospital A	-	18.2%
B	-	19.2%
C	-	21.3%
D	-	25.1%
E	-	30.9%
F	-	46.3%

The Department expects additional duplicate filings within the calendar year.

EXHIBIT 7
DATE 3-3-89
ID 340

MONTANA HEALTH CARE ASSOCIATION



36 South Last Chance Gulch, Suite A
Helena, Montana 59601
406-443-2876

SENATE BILL 340 - IS IT UNCONSTITUTIONAL TO EXEMPT HOSPITALS?

Senate Bill 340 would continue CON regulation to July 1, 1991. However, hospitals would be excluded from the CON requirements while all other health care facilities would be included. No reasons why hospitals should be treated differently from other health care facilities have been put forth. In fact, the proponents of SB 340 stated that all health care facilities should be exempted from CON for the same reasons that hospitals should be exempted.

SB 340 raises a serious constitutional question regarding the denial of equal protection of the laws.

Equal protection of the laws requires that all persons be treated alike under like circumstances. Classification of persons is allowed as long as it has a permissible purpose and the classifying statute has a reasonable relationship to that purpose.

If enacted into law, SB 340 would be reviewed by the courts under the "rational relationship" test - i.e., does a legitimate governmental objective bear some identifiable rational relationship to the discriminatory classification.

There is no identifiable governmental objective in including all health care facilities in CON except hospitals. There is considerable question whether Senate Bill 340, if enacted into law, would withstand a constitutional challenge based on equal protection.

The constitutional infirmity of Senate Bill 340 has obviously been recognized by its proponents as they have included a severability provision in the bill (Section 5). However, if Senate Bill 340, assuming it becomes law, is challenged, it will be because it is applied to a health care facility which must meet CON requirements while hospitals are exempt. If this challenge is successful, there will be no CON in Montana. This of course would not bother the proponents as their stated purpose is to eventually eliminate CON completely. Senate Bill 340 is simply a first, and maybe last step. By exempting hospitals, even though it may be an unconstitutional denial of equal protection to other health care facilities, the end of CON may be ensured.

We urge your support of Senate Bill 340 WITH AMENDMENTS to include hospitals in the process.

M E M O R A N D U M

To: File

From: Patrick E. Melby

Re: SB 340

Date: February 14, 1989

Certificate of need is an exercise of a state government's inherent "police power" to protect public health, safety, and welfare. It is a regulatory program in which a state administrative agency is delegated quasi-legislative and quasi-judicial powers by the legislature to grant or deny a certificate, similar to a permit or license, which is a legal prerequisite to constructing or modifying a health care facility. The rationale underlying CON is that for a number of reasons - e.g., the non-profit status of most hospitals, a financing system and patterns of consumer behavior which stifle price competition, some elements of the monopoly behavior, the inability to define and measure "health care" - ordinary market forces will not operate to prevent the duplication of institutional services or the use of resources in an inefficient, uncoordinated, and wasteful manner. The Guide to Health Planning Law (1987) page XX.

Montana's CON law generally applies to all health care facilities as defined in 50-5-101 (19) MCA. A health care facility may not build new beds, add a new health service or make capital expenditures for equipment over \$750,000 or for construction over \$1,500,000 without a CON.

Senate Bill 340 would continue CON regulation to July 1, 1991. However, hospitals would be excluded from the CON requirements while all other health care facilities would be included. There was absolutely no testimony at the Senate Public Health and Welfare Committee Hearing on Senate Bill 340 to establish a reason why hospitals should be treated differently from all other health care facilities. In fact, the proponents of SB 340 stated that all health care facilities should be exempted from CON for the same reasons as hospitals.

SB 340 raises a serious constitutional question regarding the denial of equal protection of the laws.

ENTERED 7
DATE 3-3-89
HB 340

The right to carry on a lawful business is a property right and due process requires that it not be unreasonably or unnecessarily restricted. However, the regulation of the lawful business by the state is a valid exercise of its police power. Equal protection of the laws requires that all persons be treated alike under like circumstances. Classification of persons is allowed as long as it has a permissible purpose and the classifying statute has a reasonable relationship to that purpose. Billings Associated Plumbing, Heating and Cooling Contractors v. State Board of Plumbers, ____ Mont. ____, 602 P.2d 597, 600 (1979).

There is no fundamental right or invidious discrimination involved in Senate Bill 340, therefore, the bill is not subject to the "strict scrutiny" test of equal protection. For this reason, the bill, if enacted into law would be reviewed under the "rational relationship" test - i.e., does a legitimate governmental objective bear some identifiable rational relationship to a discriminatory classification. Cottrill v. Cottrill Sodding Service, ____ Mont. ____, 744 P.2d 895, 897 (1987).

The Supreme Court has stated it succinctly thus:

A classification that is patently arbitrary and bares no rational relationship to a legitimate governmental interest offends equal protection of the laws. (cites omitted). As we have previously held equal protection of the laws requires that all persons be treated alike under like circumstances.

Tipco Corp., Inc. v. City of Billings, 197 Mont. 339, 346, 642 P.2d 1074, 1078 (1982).

The court in trying to determine the governmental interest in making a classification will generally (1) attempt to ascertain the governmental objective from the face of the statute; (2) review the legislative history; or (3) consider other evidence of what objective the legislature may have had in mind at the time of passing the legislation. See Cottrill v. Cottrill Sodding Service, Supra at 897.

Using the rational relationship test, the Montana Supreme Court has several times found state statutes or city ordinances unconstitutional as a violation of equal protection. In Cottrill v. Cottrill Sodding Service, Supra, the court found that a state statute which excluded from workers' compensation coverage an employer's family member who resided in the employer's household unless the employer

EXHIBIT 7
DATE 3-3-89
2/16

specifically elected to include the employee,
unconstitutional as a denial of equal protection.

In Tipco Corp., Inc. v. City of Billings, Supra, the Supreme Court found an ordinance by the City of Billings which declared uninvited door-to-door solicitation a nuisance punishable as a misdemeanor but exempted local merchants with regular established places of business from its operation as unconstitutional. The City of Billings had argued that the ordinance had a rational relationship to the city's objectives because it could exercise control over local merchants and their uninvited door-to-door solicitations but could not exercise such control over out-of-state firms and their solicitors. The state rejected this rational and found the ordinance unconstitutional.

In Godfrey v. Montana State Fish and Game Commission, ___, Mont. ___, 631 P.2d 1265 (1981) the Supreme Court found a state statute which required a person to be a resident of Montana to qualify for an outfitter license to be unconstitutional. The state argued at page 1268 of 631 P.2d, that the discrimination was justified because:

The statutes were enacted pursuant to the police power to control the activities of outfitters to ensure the safety of persons utilizing their services within the borders of Montana, to protect private property rights, and to ensure reasonable law enforcement ability in preserving and protecting the wild life of Montana.

The court found that none of the reasons offered to justify the discrimination were persuasive. 631 P.2d 1268.

And the court found a statute which required a non-resident hunter to be accompanied by a licensed outfitter unconstitutional in the case of State v. Jack, ___, Mont. ___, 539 P.2d 726 (1975). The court found the statute unconstitutional even though it was allegedly designed to promote safety for hunters, to foster better protection for private land owners and to provide more effective law enforcement. The court found that the relationship between the statutory classification and its legitimate objectives was tenuous and remote and was, therefore, insufficient to justify the inequities it engendered. See 539 P.2d at page 730.

There is considerable question whether Senate Bill 340,

EXHIBIT 7
DATE 3-3-89
HB 340

Memorandum
February 14, 1989
Page 4

if enacted into law, would withstand a constitutional challenge based on equal protection.

The constitutional infirmity of Senate Bill 340 has obviously been recognized by its proponents as they have included a severability provision in the bill (See Section 5). Severability clauses are not included in legislation unless there is a question of constitutionality of part of the bill. The inclusion of a severability clause only provides a presumption that the legislature intended that if the invalid part of the statute is severable from the rest, the portion which is constitutional may stand while that which is unconstitutional is stricken. If, when an unconstitutional portion of an act is eliminated, the remainder is complete in itself and capable of being executed in accordance with the apparent legislative intent, it must be sustained. Montana Automobile Association v. Grely, at page 311 of 632 P.2d.

However, the inclusion of a severability section is no guarantee that the entire act will not be found invalid if a portion of it is constitutional. If a portion of an act is found unconstitutional and the remainder is not complete in itself or is incapable of being executed in accordance with legislative intent, the whole act will be found invalid. North Central Services, Inc. v. Hafidahl, ___, Mont. ___, 625 P.2d 56, 59 (1981).

If Senate Bill 340, assuming it becomes law, is challenged, it will be because it is applied to a health care facility which is not a hospital which must meet CON requirements while hospitals are exempt. It is hard to contemplate a situation where a successful challenge would not invalidate the entire CON procedure. This of course would not bother the large metropolitan hospitals as their primary purpose is to eventually eliminate certificate of need completely anyway. Senate Bill 340 is simply a first, and maybe a last step. By exempting hospitals even though the bill may raise a question of an unconstitutional denial of equal protection to other health care facilities, hospitals ensure the end of certificate of need.

PEM

EXHIBIT 7
DATE 3-3-89

MONTANA HEALTH CARE ASSOCIATION



36 South Last Chance Gulch, Suite A
Helena, Montana 59601
406-443-2876

For information contact: Rose M. Hughes
Executive Director

SENATE BILL 340 - to remove hospitals from certificate
of need process

Hospitals should not be removed from health planning because
of their impact on the Medicaid budget. Hospital service
costs are growing faster than any other part of the Medicaid
budget.

MEDICAID PAID CLAIMS STATISTICS FY87 thru 1/31/89:
(from SRS print out)

<u>Service</u>	<u>FY87</u>	<u>FY88</u>	<u>89 YTD</u>
<u>Inpatient Hospital</u>			
Dollars	\$29,861,585	\$34,101,800	\$12,225,494
Services	2,002,803	2,114,452	658,884
Cost per service	\$14.90	\$16.12	\$18.55
INCREASE COST PER SERVICE		+8.1%	+15%
<u>Outpatient Hospital</u>			
Dollars	\$4,667,976	\$5,579,224	\$2,520,944
Services	456,829	385,220	145,665
Cost per service	\$10.21	\$14.48	\$17.30
INCREASE COST PER SERVICE		+42%	+19%
<u>Physicians</u>			
Dollars	\$11,266,278	\$12,205,821	\$4,945,929
Services	492,417	548,674	224,174
Cost per service	\$22.87	\$22.24	\$22.06
INCREASE COST PER SERVICE		-2.7%	-.8%
<u>Other primary care:</u>			
Dollars	\$22,669,745	\$23,676,691	\$10,655,574
Services	3,010,180	3,609,317	1,538,318
Cost per service	\$ 7.53	\$ 6.56	\$ 6.92
INCREASE COST PER SERVICE		-12.8%	+5.5%

An Affiliate of
alca
American Health Care Association

EXHIBIT 7
DATE 3-3-89
HB 340

Service

Nursing home costs:

Dollars	\$45,845,522	\$48,101,403	\$24,708,879
Days of Care	1,278,561	1,317,427	661,771
Cost per day	\$35.86	\$36.51	\$37.34

INCREASE COST
PER DAY

+1.8%

+2.3%

SUMMARY

Increase or Decrease in Cost Per Service:

Service

FY87 - FY 88

FY88 - 89YTD

Inpatient Hospital	+8.1%	+15.0%
Outpatient Hospital	+42.0%	+19.0%
Physicians	- 2.7%	- .8%
Other primary care	-12.8%	+ 5.5%
Nursing homes	+ 1.8%	+ 2.3%

It is clear that hospital services, both inpatient and outpatient, are the services responsible for the fastest growth rate. The cost per service is growing at a rate that far exceeds inflation, while other health service costs are growing at rates that are less than general inflation.

SUPPORT CERTIFICATE OF NEED FOR ALL HEALTH CARE PROVIDERS,
INCLUDING HOSPITALS.

EXHIBIT 7
DATE 3-3-77
BY 240

MEDICARE PAID CLAIMS STATISTICS
As of 12/31/87

Fiscal Year ends	83	84	85	86	87	88	89
Inpatient Hospital Dollars	\$14,514,819	\$15,624,371	\$15,785,000	\$20,567,240	\$25,601,581	\$34,101,500	\$19,221,444
Services	104,794	103,981	155,522	1,757,081	2,002,803	2,114,452	552,884
	142.32	174.57	124.04	15.00	14.90	16.12	18.55
Outpatient Hospital Dollars	\$1,875,639	\$2,072,039	\$2,512,527	\$2,565,624	\$4,607,976	\$5,579,224	\$1,520,944
Services	76,026	71,101	82,565	312,025	456,829	381,220	143,665
	26.79	29.15	30.44	11.42	10.21	14.48	17.30
Physicians Dollars	\$4,754,850	\$4,905,045	\$7,804,651	\$5,547,657	\$11,261,272	\$12,205,821	\$4,945,929
Services	289,140	291,231	341,786	415,511	492,417	545,674	224,172
	17.12	23.38	22.58	23.08	22.87	22.24	22.06
Other Primary Care Costs Dollars	\$5,824,477	\$11,715,720	\$12,643,261	\$16,445,511	\$22,665,741	\$25,674,691	\$10,455,574
Services	855,162	471,212	2,442,172	2,442,172	3,015,180	3,604,517	1,539,218
	10.56	33.07	—	7.55	7.53	6.56	6.92
Primary Care Costs	\$91,921,685	\$43,726,175	\$46,751,440	\$57,924,512	\$66,423,584	\$75,565,556	\$30,247,941
Nursing Home Costs Dollars	\$27,191,641	\$31,751,283	\$39,702,695	\$41,255,545	\$42,841,522	\$45,101,405	\$24,708,675
Days of Care	1,042,114	1,241,095	1,221,525	1,230,925	1,278,561	1,317,627	661,771
	26.07	31.22	32.50	34.00	35.82	36.51	37.34

i Does NOT include Dept. of Institutions Nursing Home costs

xi The definition of units of I/H hospital services was changed in this fiscal year.

EXHIBIT

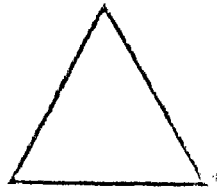
DATE 3-3-89

HB 340

8.17% 15.1%

1.8% 2.3%

MONTANA HEALTH CARE ASSOCIATION



SB 340

36 South Last Chance Gulch, Suite A
Helena, Montana 59601
406-443-2876

MEDICAID BUDGET

Effect of each 1% increase in utilization of various
health care services:

	<u>1%</u>	<u>10%</u>
Nursing homes	\$516,643	\$5,166,430
Inpatient Hospital	385,805	3,858,050
Outpatient Hospital	65,942	659,420

Granite County Memorial Hospital & Nursing Home

110 Cassome Street
Helena, Montana 59601

P. O. Box 729
PHILIPSBURG, MONTANA 59858

February 13, 1989

Montana State Legislators
State Capitol
Helena, Montana 59620

Dear Senators and Representatives:

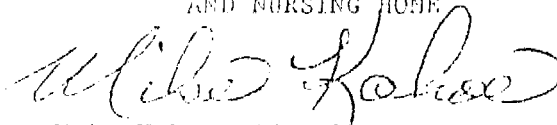
Please be advised that I strongly support the continuation of the Certificate of Need process and believe that it should cover the entire health care field, including hospitals.

I am the Administrator of Granite County Memorial Hospital and Nursing Home in Philipsburg, as well as a member of the Board of Directors of the Montana Health Care Association, so I am very familiar with the Certificate of Need process.

The process eliminates duplication of services and helps hold down health care costs for everyone. Your vote to continue Certificate of Need would be very much appreciated.

Sincerely yours,

GRANITE COUNTY MEMORIAL HOSPITAL
AND NURSING HOME

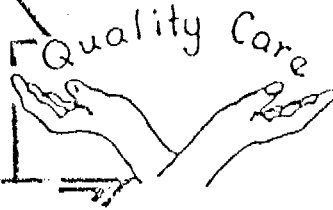


Mike Kahoe, Administrator

BK/me

ENTRUSTED 7
DATE 3-3-89
RE 346

McCONE COUNTY
HOSPITAL
P.O. BOX 47
CIRCLE, MONTANA 59215



Montana Senators and Representatives
c/o Rose Hughes
Montana Health Care Association
36 South Last Chance Gulch Suite A
Helena, Montana 59601

February 13, 1989

Dear Honored Senators and Representatives:

RE: SB 340

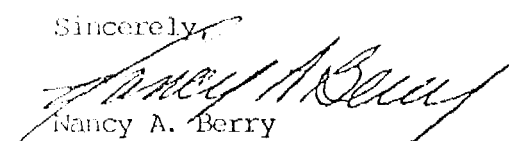
I would like to make known my opposition to Senate Bill 340, regarding the exclusion of hospitals from the Certificate of Need (CON) process.

The CON process was developed to apply to all healthcare facilities and to effectively control their growth in a positive manner. As you are well aware, health care financing is an important and complicated issue. In order for the CON process to have the desired effect on health care spending, it must apply not only to nursing homes but also to hospitals. I would be disappointed to think that short term personal interests are being substituted for long term planning and benefits.

As an administrator of both a hospital and nursing home, I urge you to study this issue and consider opposing Senate Bill 340.

Thank You,

Sincerely,


Nancy A. Berry
Administrator

cc: Cecil Weeding

EXHIBIT 7
DATE 3-3-89

Dahl Memorial Hospital Association

P.O. Box 46

Enkalaka, Montana 59324

February 28, 1989

Rose Hughes
Executive Director
Mt. Health Care Assn.
36 S. Last Chance Gulch, Suite A
Helena, Montana 59601

Dear Rose:

Certificate of Need legislation has plagued health care providers in all the states in which I have been an administrator, mainly Montana and North Dakota.

I have always felt that the CON law has accomplished most of what it was designed to do. I'm only for the CON law when it effects all providers in the same manner. It now appears there are certain forces that think the large hospitals should be exempt from the CON law.

It is the feeling of myself and the Board of Directors, Dahl Memorial Healthcare Association that there should be a CON law and that providers should be subjected to it in the same manner.

Thank you.

Sincerely,

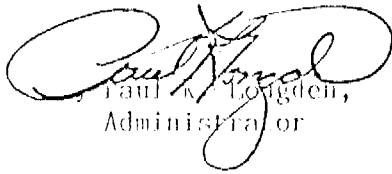

Paul K. Longden,
Administrator

EXHIBIT 7
DATE 3-3-89
HB 340

Glacier County Medical Center

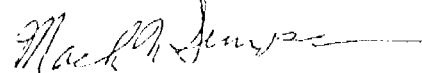
802 2nd St. SE
Cut Bank, MT 59427
(406) 873-2251

February 14, 1989

TO: All Montana Senators and House Representatives

We support the Certificate of Need process. All health care facilities should have the same requirements.

Sincerely,



MACK N. SIMPSON
Administrator

DATE 3-3-89

Prairie Community Hospital & Nursing Home

312 SOUTH ADAMS AVE

P.O. BOX 156 • TERRY, MONTANA 59349-0156

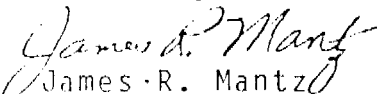
February 13, 1989

Bill Good
Montana Health Care Association
Last Chance Gulch
Helena, Montana 59601

Dear Mr. Good:

In reference to Senate Bill # 340 entitled "An Act to Revise and Continue the Certificate of Need Laws", we feel that hospitals should be included in the certificate of need process along with other health care facilities.

Sincerely,


James R. Mantz
Administrator

FILED 7
DATE 3-3-89
HB 340

ROOSEVELT MEMORIAL HOSPITAL AND NURSING HOME

P.O. Drawer 419

CULBERTSON, MONTANA 59218

(406) 787-6021

TO: Members of the Montana Legislature
FROM: Paul Hanson, Administrator
DATE: February 24, 1989
RE: SB 340

As the Administrator at Roosevelt Memorial Hospital and Nursing Home I would ask that you support Senate Bill 340.

I have conferred with Rose Hughes, President of the Montana Health Care Association and I concur with her understanding of that Bill and give her my full support.

FILED 7
DATE 3-3-89
HB 340

MONTANA HEALTH CARE ASSOCIATION



36 South Last Chance Gulch, Suite A
Helena, Montana 59601
406-443-2876

SENATE BILL 340 - exempting hospitals from CERTIFICATE OF NEED

CERTIFICATE OF NEED IS THE ONLY PROTECTION THE STATE OF MONTANA HAS IN PLACE TO PROTECT CONSUMERS FROM THE HIGH COSTS ASSOCIATED WITH UNNECESSARY INVESTMENT IN HEALTH CARE FACILITIES AND DUPLICATION OF SERVICES.

DEREGULATION LEADS TO EXCESS CAPACITY AND HIGHER COSTS.

Let's look at the "Utah experience."

The following are all excerpts from a report on Utah deregulation entitled "An Examination of the Long Term Care Industry in Utah", released in September, 1988.

"There has been rapid growth in the number of long term care beds in Utah since the repeal of Certificate of Need."

1,445 new beds were added and occupancy dropped from 90% to 75%.

"The increase in beds demonstrates that the market was not successful at guarding against excess capacity and overbuilding."

"A lower occupancy rate increases the per patient cost of care."

"Where the influx of providers and new beds are most prominent is in the area of new free-standing psychiatric hospitals. Since January 1, 1985, eight new free-standing psychiatric hospitals have been built in the state for a total of 550 new licensed beds. ...Although one or two psychiatric hospitals may actually have been needed, it is generally thought that there is now a substantial excess of such beds..."

"The increase in beds in the above areas demonstrate that the market was not successful at guarding against excess capacity and overbuilding."

"Per unit costs increase with declining occupancy. Fixed costs, such as housekeeping, mortgage payments, and equipment, remain constant regardless of occupancy. ...As occupancy declines, these costs must be spread over a smaller number of patients."

"If Medicaid expenditures on long term care are not controlled, the

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DATE 3-3-89
HB 340

number of individuals served or the number of services provided by the Medicaid program will have to be reduced."

"An even more serious concern lies in the realm of quality of care. ...The care a facility provides just before it goes under is likely to be of dubious quality. Even before reaching that point, facilities may be cutting corners in the areas of food, staffing, wages, and benefits...."

"In addition, there is the problem of relocating patients when a facility closes. This is very traumatic and destroys adjustments or relationships the patient has made..."

"In many states where Certificate of Need has been repealed without employing a moratorium or other restrictive mechanism, there has been considerable growth in the long term care bed supply and a corresponding decrease in occupancy. Low occupancy rates increase the per patient cost of providing care."

You are being asked to abandon your concern for patients, consumers, and taxpayers, and to risk major increases in the Medicaid budget, to satisfy a few hospitals which find certificate of need inconvenient

PLEASE SUPPORT SENATE BILL 340, WITH AMENDMENTS TO INCLUDE HOSPITALS IN THE PROCESS.

AN EXAMINATION OF THE LONG TERM CARE INDUSTRY
IN UTAH AND THE FUTURE IMPLICATIONS
TO CERTIFICATE OF NEED

by

Heidi M. Erich
Graduate Student
Arizona State University

Presented to

Suzanne Dandoy, M.D., M.P.H.
Executive Director
Utah Department of Health

Rod L. Batte
Director
Division of Health Care Financing

September 1, 1988

EXHIBIT 7
DATE 3-3-89
HB 340

TABLE OF CONTENTS

I.	EXECUTIVE SUMMARY	Page 1
II.	INTRODUCTION	Page 3
III.	BACKGROUND OF CERTIFICATE OF NEED	Page 4
IV.	IMPACT OF DEREGULATION	Page 6
V.	MARKET CONDITIONS OF THE LONG TERM CARE INDUSTRY .	Page 8
VI.	INSTITUTIONAL FACTORS	Page 9
VII.	STATE STRATEGIES	Page 13
VIII.	DIFFICULTIES WITH REINSTATING CON	Page 16
IX.	STRATEGIES TO BE EXAMINED	Page 19
X.	NEED FOR ADDITIONAL INFORMATION	Page 24
XI.	ADDITIONAL RECOMMENDATIONS	Page 25
XII.	BIBLIOGRAPHY	Page 27
	APPENDIX	Page 31
	1 - Net Change in Geriatric Beds	
	2 - Projected Number of Beds Required for Those 65 and Over	

I. EXECUTIVE SUMMARY

This paper examines the current condition of skilled and intermediate care facilities in Utah. It traces the Certificate of Need program, repealed in 1984, and evaluates the future implications for the long term care industry in the State. The report also assesses how other states are meeting the challenges posed by a projected increase in the number of people requiring long term care services within the context of limited resources. It is recommended that the State move to limit construction while fostering the growth of competitive forces.

Information for this report was collected from a variety of resources. A computer search and a review of the professional literature was completed, a telephone survey of every state was made, and interviews were conducted with a number of people in Utah on all sides of the long term care and Certificate of Need issues.

The Utah Certificate of Need program was an outgrowth of the federal health planning movement. Section 1122 and Certificate of Need were designed to control health care expenditures by discouraging or preventing "unnecessary" investment in health facilities. This was justified because it was argued that the market was unable to control health care costs.

Utah had a program to review capital expenditures from 1974 through 1984. During this ten year period the supply of beds in hospitals and nursing homes was tightly controlled. Emphasis later shifted from a "health planning" approach to an "open market" strategy for controlling rising costs. Implementation of free market forces and price competition was seen as an innovative way to control the growth of health care costs. The Certificate of Need law was repealed as a component of this policy.

There has been rapid growth in the number of long term care beds in Utah since the repeal of Certificate of Need. While Certificate of Need was in place, only 99 additional long term care beds were approved. Following the repeal of the program there was a net increase of 216 beds in 1985, 644 beds in 1986, and 585 beds in 1987. The large increase in beds has caused the average nursing home industry occupancy rate to plummet from almost 90 percent to 75 percent. The increase in beds demonstrates that the market was not successful at guarding against excess capacity and overbuilding.

A lower occupancy rate increases the per patient cost of care. At the same time other factors, including the nursing shortage, past and future changes in staffing requirements, and patients with heavier care needs, have increased operating costs for nursing homes. During this period there have been only small increases in the Medicaid flat rate paid to nursing homes. The financial situation of the industry as a whole has deteriorated. If the growth continues this condition will worsen.

If the current trend is allowed to run its course, it will bring about the closure of a number of nursing homes, relocation of patients, and diminished quality of patient care due to cuts in expenditures for food, activities and staffing. There may also be a negative impact on the Medicaid budget. A worsening of the financial situation in nursing homes will increase the pressure on the preadmission screening program to allow more patients into facilities and on Medicaid to increase the rate paid for care. This money may have to come from programs designed to provide care to other indigent and ill people.

Other states are also working to control Medicaid expenditures for long term care. In some states, controlling the supply of long term care beds is viewed as an effective means of controlling expenditures. States with strong regulatory agencies have high average nursing home industry occupancy rates. States with little or no regulation tend to have a lower average census. There are difficulties associated with both very high and very low nursing home occupancy rates.

The Certificate of Need programs vary widely from state to state. The programs are effective and more readily accepted where there is a longstanding interest in government regulation. This attitude is not present in Utah.

A Certificate of Need program would be very expensive and difficult to reinstate. There are additional concerns about the program such as its cost, the length of the appeals process, and the impact of political influence. At this time, reinstating a capital expenditure review program is unlikely to be politically successful or desirable.

The most effective strategy to handle the situation in the long term care industry is a plan to provide relief from incessant construction while assessing the feasibility of price competition. Prohibiting new construction will halt the sharp decline of occupancy rates, allowing facilities to better cover costs. A pilot project will allow nursing homes in a small area to compete for new Medicaid admissions on the basis of quality and price of care. At present, competitive forces are not at work in the long term care market. This pilot project will lay the foundation for future competition. Such a move addresses the current situation while adhering to the policy of promoting competition as a way of controlling cost.

Other recommendations in the report include collecting more relevant demographic and utilization data, increasing funding to nursing schools to increase enrollment, encouraging the development of private long term care insurance, and investigating other innovative ways to finance long term care.

II. INTRODUCTION

Since the repeal of Certificate of Need in Utah in 1984 there have been a number of changes in the long term care industry. The number of nursing home beds has increased rapidly. Operating costs of nursing homes have risen. A serious shortage of nursing personnel has developed. If conditions continue to worsen, there may be a serious impact on the quality of care in nursing homes and on the overall Medicaid budget. The purpose of this paper is to examine the prevailing conditions in the long term care industry in the state of Utah, the Certificate of Need program, and the experience in other states, and to evaluate possible solutions.

Section three reviews the background of the Certificate of Need program. It outlines the political roots of the program, evaluates its success, and describes Utah's innovative approach to control health care costs. Section four traces the developments since the repeal of Certificate of Need. Areas where there has, and has not, been a flurry of construction are examined. It also looks at possible explanations for the rapid growth in long term care beds for the elderly in Utah. Section five describes the factors present in the long term care market. It notes those elements distinguishing long term care from a competitive market. In section six the long term care industry is investigated. The factors increasing operating costs for nursing homes are examined, and the reasons why this is of concern to State Government and the Medicaid program are highlighted. Strategies other states use in an attempt to balance the competing goals of assuring access while providing low cost and high quality care are described in section seven. Every strategy has accompanying difficulties. Section eight notes the difficulties in reinstating a Certificate of Need program at this time in the state of Utah. Although it did control bed supply and many states still have such a program, reintroducing such a program at this point in time would be likely to encounter a great deal of political opposition and also be expensive. Since it is not an appropriate time to revive a capital expenditure review program, other strategies to deal with the problems posed in long term care are examined in section nine. The options are outlined and a solution consistent with the concern over the current situation and consistent with Departmental policy is proposed. Section ten covers the need for information in order to make decisions in the future, and section eleven specifies some issues which should be investigated further. Section twelve cites the resources used in completing this research.

III. BACKGROUND OF CERTIFICATE OF NEED

The Certificate of Need program had its roots in the health planning movement. One of the first moves toward comprehensive health planning was the Hospital Survey and Construction Act of 1946, commonly referred to as the Hill-Burton Act. It provided funds for construction of health care facilities. Initially, a bed/population formula was used to identify underserved areas. In 1966, the "Comprehensive Health Planning Act" was passed, which was intended to assess health service needs and make changes. The program was given little authority to actually bring about these changes, however.

Under Section 1122 of the 1972 Social Security Act Amendments, a state-optional program could be adopted to review capital expenditures proposed by health care facilities. If states gave a negative recommendation, reimbursement for capital costs associated with the project were withheld under Medicare and Medicaid. This was not always an effective deterrent, since the amount of Medicare and Medicaid funding received by institutions varied, as did the size of the penalty. In some cases there were only very weak penalties if an institution went ahead with the project without approval. States also began to define their own certificate of need programs to review the provision of new services and the construction or major renovation of health care facilities. Certificate of need programs generally had broader coverage than 1122 programs and also carried more substantial penalties for noncompliance.

The first certificate of need (CON) program was begun in New York in 1964. The "National Health Planning and Resource Development Act of 1974" was passed in 1975. It made funding available for state planning activities, and authorized the creation of State Health Planning and Development Agencies (SHPDAs) and Health System Agencies (HSAs). These agencies were put in place to prepare comprehensive health plans which were then to be used in the CON review process. This Act effectively required states to implement CON programs according to federal standards. If they did not, states lost federal funding for state health planning and health resource development. "By January 1975, 46 states and the District of Columbia had certificate of need, Section 1122, or both."¹

CON programs were designed to discourage or prevent what was deemed by the planning agencies as "unnecessary" investment in health facilities. Health facility construction and capital expenditures were reviewed on the basis of community need, not demand. The need for such a review was supported by citing areas of "market failure" in health care. Market failure occurred because: there was little or no information available to consumers about price or quality, third party

¹ James B. Simpson, "State Certificate of Need Programs: The Current Status," American Journal of Public Health 75 No. 10 (October 1985): 1225.

reimbursement shielded consumers from the cost of health services, and the physician (not the patient) often determined when care was necessary and where the care would be given. CON programs were also used to control health expenditures by controlling bed supply, capital investments in new equipment, and new services. The rationale for controlling supply to control costs was supported by research that indicated there was supply induced demand for hospital beds.² (Roemer's law: A built bed is a filled bed). CON programs included provisions for public hearings and administrative and judicial appeals.

Utah agreed to review capital expenditures in 1974. In 1976, the Utah Health Planning and Resource Development Act was passed. The Act created a local Health Systems Agency, and a State Health Planning and Development Agency. By 1979 a CON program complying with federal standards, the "Utah Pro-Competitive Certificate of Need Act," was enacted. This replaced 1122 review. The Act was amended and reenacted in 1981 and 1983.

The Certificate of Need program in Utah did a good job of controlling bed supply. It was much less successful in controlling major capital equipment purchases or the provision of new services. The focus of the program on controlling beds forced hospitals to diversify in areas not as tightly controlled. See Appendix 1.

After the Reagan Administration came into office in 1980, emphasis was shifted from health planning to market forces. The "National Health Planning and Resources Development Act" expired in 1982.

In February, 1983, the Utah Department of Health published a statement of health policy entitled, A Prescription for Health Care Costs in Utah. The report noted that health care costs in Utah were lower than in the rest of the nation, but that the rate of increase was greater. The strategy recommended dealing with rising health care costs by establishing "price competition as the controlling factor in the health care market" and allowing market forces to take over. It recommended discontinuing the CON program. The report also noted, "most health economists believe that the establishment of price competition in any given area will take between six and eleven years. Because of this fact there has always been concern that the strategy will be dropped before it has a chance to develop." The Certificate of Need program was terminated by the State Legislature on December 31, 1984.

²M. Roemer and M. Shain, Hospitalization Under Insurance (Chicago: American Hospital Association, 1959).

IV. IMPACT OF DEREGULATION

The repeal of Certificate of Need legislation was based on the premise that the free market could more efficiently control health care costs than could regulation. Some argued that free market forces were not in place in areas of the health care market. In order to establish price competition, several important changes in the environment were proposed in A Prescription for Health Care Costs in Utah. These included establishing health insurance plans with "a financial incentive to consider costs at the time health care is purchased," and making information about the cost and quality of health care available to consumers.

It was hoped that the free market forces already in place would be sufficient to deter overinvestment once the control of certificate of need was lifted. Establishing price competition was expected not only to control health care costs but also to increase efficiency in the market. Copayments and deductibles were to be introduced into third party reimbursement to make consumers more aware of the cost of care. As consumers became more conscious of the cost of their health care, they were expected to want to become more informed before making choices. The Utah Health Cost Management Foundation (a coalition of business and industry) and the Utah Department of Health were directed to publish information on health care cost trends in the early years, and information about the relative quality of health care sold by individual and institutional providers in the later years.

Since the termination of CON, overbuilding has not been a problem in the area of intermediate care facilities for the mentally retarded, where there have been additions of only a few beds; or for general acute care hospitals. No new acute care hospitals have been built since the repeal of CON. Where the influx of providers and new beds are most prominent is in the area of free-standing psychiatric hospitals. Since January 1, 1985, eight new free-standing psychiatric hospitals have been built in the State for a total of 550 new licensed beds. The majority of these beds were built along the Wasatch Front. Although one or two psychiatric hospitals may have actually been needed, it is generally thought that there is now a substantial excess of such beds. Occupancy rates are low for most of these facilities. At the time of this report, Medicaid was not reimbursing for psychiatric care provided in free-standing facilities. However, the pressure for Medicaid to cover care in this setting was mounting.

Prior to the demise of CON in 1984, few new nursing home beds had been approved by the review agency. Virtually no beds were approved between 1979 and 1983. From January, 1983 through December 31, 1984, 99 additional beds were approved. In 1985 there were 159 new geriatric nursing home beds built. There were also 129 beds converted to geriatric use, but 27 beds were lost for a net increase of 261 beds. The growth escalated in 1986. In that year, 635 new beds were built, and 31 hospital beds were converted to "transitional" care, although 22 beds

were lost or converted, for a net increase of 644 beds. The year 1987 showed similar growth with 615 new licensed geriatric beds, although 20 beds were lost for a net increase of 585 beds. The expansion may be slowing now. In the first six months of 1988 were additions of 19 new beds, and the conversion of 14 hospital beds to transitional care. In 1988, 42 beds that were geriatric care beds were converted to other use, and 53 beds are no longer licensed, for a net decrease of 62 beds. However, plans have been submitted to the Bureau of Facility Licensure for 324 new beds, 120 of which are currently under construction. As of May 1, 1988, there were 1,721 empty SNF or ICF beds in the State.

Utah has a lower long term care bed to population ratio than most other states. It also has a smaller proportion of the elderly population residing in institutions. Nationally, 5 percent of the elderly over age 65 reside in nursing homes, while in Utah the figure is only 3.5 percent. If potential investors look only at the absolute number of beds instead of historical utilization and current occupancy rates, Utah may still be perceived as an attractive market. There is the danger of an explosion of long term care beds in the next several years if there are no steps taken to restrict growth. An indication that there are more beds than needed is the declining occupancy rate of the nursing homes as a whole. Statewide average occupancy rates, which were running around 90 percent in 1983, were 75 percent in June, 1988.

The increase in beds in the above areas demonstrate that the market was not successful at guarding against excess capacity and overbuilding. The long term care area of the health care market has several features which distinguish it from a competitive market.

V. MARKET CONDITIONS OF THE LONG TERM CARE INDUSTRY

In Utah the market for long term care is not a competitive market, but a monopsony. The Medicaid program is the principal buyer. In May, 1988, Medicaid supported 67 percent of the ICF/SNF and 97 percent of ICF/MR patients in the State. As the principal buyer, Medicaid does not have free access to the competitive market. Medicaid pays all certified providers according to a predetermined formula based on historical property costs and levels of care. Providers currently do not bid for the provision of services and Medicaid does not contract for only the number of needed beds. In addition, there is an almost complete lack of price sensitivity in the market.

Medicaid reimburses nursing homes on a flat rate schedule. Since the introduction of the flat rate in 1982, there has been only a 4.2 percent average annual increase in the reimbursement rate. Included in the schedule are differentials for historical property costs, return on equity (frozen at the 1981 level), and varying levels of care. Otherwise, all facilities receive the same reimbursement for Medicaid patients. There is no leeway for nursing homes to raise the price for Medicaid patients and no incentive to charge less than what Medicaid pays. Medicare will cover some skilled nursing care, but only makes up 2 percent of nursing home reimbursement nationally. Private insurance accounts for less than 1 percent of national nursing home expenditures. Out-of-pocket payment from individuals and their families comprises the balance of nursing home reimbursement. Most nursing homes do charge private patients higher rates than Medicaid patients.

Medicaid in Utah does not charge patients copayments or otherwise have them share the cost of care once they are eligible for coverage. Therefore, patients are not sensitive to the cost of care, and price does nothing to deter unnecessary utilization. A preadmission screening program is in place to make certain that individuals receiving care truly need it. There are no incentives for patients to shop for care on the basis of cost, nor is there objective information published on the quality of care provided in any given institution. The Federal Health Care Financing Administration (HCFA) will soon publish results from Medicare/Medicaid nursing facility survey reports, listing deficiencies for individual nursing facilities. The seriousness of the deficiencies may not be clear to the average reader, however. In addition, the nursing home industry maintains that the survey results are subjective and inconsistent.

Private pay patients are more sensitive to price, yet they represent only a small segment of the market. In addition, private pay patients may become Medicaid patients when their assets are diminished. Once they begin spending down their assets, it makes little difference what the facility costs, because the patient's share will be the same regardless of cost. Thus, there are no rewards built into the system for cost conscious behavior on the part of the consumer. The principal buyer pays a flat rate to all facilities, and long term care facilities must accept the rate Medicaid pays, or choose not to accept Medicaid patients at all.

VI. INSTITUTIONAL FACTORS

Several factors are increasing the operating costs for nursing homes: demands for higher wages caused by the nurse shortage, past and future increases in staffing requirements, and patients with heavier care needs. Since the repeal of Certificate of Need, the average census has declined from 89.8 percent in 1983, to 75.21 percent in May, 1988. Excluding the State Training School, the average ICF/MR census was 88.78 percent in 1988. Per unit costs increase with declining occupancy. Fixed costs, such as housekeeping, mortgage payments, and equipment, remain constant regardless of occupancy. Semifixed costs such as nursing salaries will remain constant within a certain operating range due to staffing requirements. As occupancy declines, these costs must be spread over a smaller number of patients.

The number of people entering nursing homes in Utah has been growing at a steady rate of one to two percent per year, limited in part by a very effective preadmission screening program. All Medicaid patients, and all patients who are expected to apply for Medicaid eligibility within 90 days, are required to undergo the Patient Assessment Evaluation.

Historically, only 3.5 percent of the population over age 65 in Utah live in nursing homes compared with 5 percent nationally. Factors associated with nursing home placement include extreme old age, living alone, lack of informal support from relatives or friends, the availability of community services, and difficulty with the activities of daily living. The lower percentage of Utah elderly in institutions could be due to a number of these factors or other influences.

Utah also has a lower number of beds per 1,000 population than the national average. This low bed to population ratio is appealing to investors, and may be an important factor attracting individuals and corporations to this area to build new nursing homes. There is a potential explosion of long term care beds from investors who view this as a lucrative potential market. As more beds are built, industry wide occupancy declines, there is pressure to fill the empty beds. This strains the preadmission screening program which is working to make sure only appropriate placements are made. Based on the national average of 5 percent, Utah seems to have a shortage of long term care beds. However, if the Utah average is used, a different picture emerges. Using the historical average of 3.5 percent of the population over age 65 in Utah in nursing homes, 1980 census data projected forward, and a target occupancy rate of 90%, it is projected that 6,060 SNF and ICF beds are needed in 1988. This will increase to 6,488 in 1990 and 7,337 in 1995. In June, 1988, there were 6,784 total licensed geriatric nursing care beds in the State—an excess of 724 beds. There were 324 additional beds in planning stages. If these beds are the only additional beds built, and the others remain, a surplus of beds will exist until 1994. See Appendix 2.

Looming on the horizon is another potential threat of bed expansion. Its source is the significant number of free-standing psychiatric hospitals built following the repeal of Certificate of Need here. All but one of these hospitals have a very low patient census and are experiencing financial difficulties. They were all built to nursing home specifications, so there is a potential for 496 beds in psychiatric hospitals to be converted quickly to provide long term care. Hospitals are also exploring the possibility of converting areas to long-term care to ease their occupancy problems. Two hospitals have already converted wings to "transitional care." Hospitals can more easily channel patients with subacute needs into their own wings rather than into nursing homes for skilled nursing care. Hospitals would then be creaming off the more lucrative Medicare patients, leaving nursing homes less revenue to cover operating costs.

Another issue affecting the long term care industry is the nurse shortage. In an effort to attract more nurses, "hospitals, nursing homes, and other employers have increased starting salaries and initiated incentives to attract nurses."³ The situation has a more severe impact on nursing homes than on hospitals because nurses typically are not trained to provide long term care and lack experience in the long term care setting. In addition, the wages and benefits long term care institutions are able to offer are lower than those paid by hospitals. "Registered nurses (RNs) earn an average of 35 percent less in nursing homes than in hospitals."⁴

Preliminary results from the 1987-88 Utah Registered Nurses' Licensure survey of 2,000 RNs who were eligible for relicensure but chose not to retain their Utah license, approximately 200 chose to work in a field other than nursing and 900 worked as RNs, but not in Utah. It is estimated that 78 percent of licensed Utah nurses are working as nurses in the State. Few nurses are inactive in the work force. The national unemployment rate for nursing is below one percent.

The nurse shortage causes concern about the care an institution is able to provide. According to the American Health Care Association, "The nurse shortage is clearly handicapping our ability to provide quality care."⁵ By October 1, 1990, facilities will be required by the federal government to have at least one registered nurse on duty 8 hours per day, 7 days per week, and at least one licensed nurse on duty 24 hours per day, 7 days per week. These requirements passed by Congress will further exacerbate the nurse shortage.

³Diane Blake, "Nurse Shortage Has Broad Implications," Pro Re Nata, 10 No. 2. (March/April 1988).

⁴American Health Care Association, Issue Paper, "Eliminate Restrictions on Labor Costs for Nursing Staff"

⁵Ibid.

Because of high turnover, there is no longer a stable, constant work force providing care to the elderly and chronically ill individuals in nursing facilities. Especially when the patient is confused or disoriented, familiar faces and a set routine can be comforting. Stability of the staff is a necessary component to high quality care, which declines sharply with excessive turnover. In addition, nurses are leaving positions just when they have completed the training process. "High turnover among workers and growing use of temporary employees have affected patients, too."⁶ This disrupts the continuity of care patients receive.

According to some Utah nursing home administrators, there is also a shortage of qualified nurses' aides. This is a view shared by Congress which included in 1987 legislation a provision that nurses' aides must be certified and a registry established. This is likely to make it more difficult for facilities to locate and hire aides, even though Medicaid will be required to cover the cost of implementing this policy. If Congress raises the minimum wage, this will have an even stronger impact on long term care institutions. Not only will it be expensive to pay aides more, but there is a ripple effect. Wages for other staff members will also have to be increased. This may exert extreme financial pressure on nursing homes. This problem is further exacerbated by the decline in the population age group (17-25) which typically fills these positions.

The characteristics of the patients are also changing. The typical nursing home resident is becoming older and needs more care. In the past, nurses had only a few patients with heavy care needs and could concentrate their time with these patients. Today, heavier care needs, in both hospitals and nursing homes, cause nurses to spread their care more thinly among a group of very elderly or ill patients.

The new beds built in Utah since 1983 have surpassed the current demand for care, resulting in declining occupancy rates. This increases the per patient per day cost of care. Nursing homes are competing with each other to staff facilities with nurses and nurses aides. This competition will intensify as the new federal staffing requirements are implemented.

A 1986 report on the profitability of nursing homes showed that on average reported revenue was in excess of costs. Exact data on nursing home profitability since then is not available. However, according to Dennis McFall, President of the Utah Health Care Association, 12 facilities have filed for Chapter 11 bankruptcies in 1988.

The declining financial viability of nursing homes and the increasing number of empty beds put financial pressure on the Medicaid

⁶Milt Freudenheim, "Nursing Homes Face Pressures that Imperil Care for Elderly." New York Times Saturday, May 28, 1988.

program. There will be a greater push by the homes to increase the reimbursement rate paid and to allow more people to enter nursing homes to fill the empty beds.

However, the Medicaid budget and the State budget are limited. Unless more funding becomes available, increasing expenditures in one area force cutbacks to be made in other areas. If Medicaid expenditures on long term care are not controlled, the number of individuals served or the number of services provided by the Medicaid program will have to be reduced.

An even more serious concern lies in the realm of quality of care. The elderly, chronically, and mentally retarded persons in nursing facilities often do not have the ability to defend themselves or to safeguard their rights. The care a facility provides just before it goes under is likely to be of dubious quality. Even before reaching that point, facilities may be cutting corners in the areas of food, staffing, wages, and benefits. These changes may be difficult to detect from the outside, but may make an enormous difference to the individual eating the food or relying on a staff member.

In addition, there is the problem of relocating patients when a facility closes. This is very traumatic and destroys any adjustments or relationships the patient has made. In smaller communities, the nursing home that closes may be the only one within 100 miles, so the patient is removed from friends and family.

The Nursing Home Profitability report noted that "a typical operation should maintain a floor of 80 percent occupancy" and recommended that "in order to maintain a healthy industry, the State should monitor this status and, perhaps, take action to discourage new facilities from entering the marketplace until levels are stabilized."⁷

⁷Peat Marwick, Study of Nursing Home Profitability for the State of Utah December, 1986.

VII. STATE STRATEGIES

The Medicaid program is administered differently by each state. Consequently, there is wide variation across programs. The percent of the Medicaid budget devoted to long term care ranges from 26 to 65 percent in the states. In Utah, 31 percent of the Medicaid budget goes to long term care. Medicaid is the principal source of financing for institutional long term care, and long term care makes up the largest single component of the Utah Medicaid budget. Each state's program has evolved within a specific regulatory environment and has its own unique challenges, but every state is faced with the dilemma of striking an appropriate balance between cost, quality and access.

States have approached the challenge of controlling the rate of growth of long term care expenditures in a number of different ways. One strategy is to restrict the number of beds available. This is based on the assumption that as the supply of beds increases there is increasing pressure to fill them (Roemer's law). Certificate of Need programs and moratoriums on construction are the primary methods used to restrict bed growth. States may also try to signal the industry to limit expansion by limiting the number of beds Medicaid will certify. If construction of facilities intended only for privately paying patients is still permitted, there is the potential that there will then be pressure on the state to allow the beds to later become Medicaid certified after they are built.

States which have strong CON programs and have been successful in controlling bed supply, tend to have high average occupancy rates and concerns about access to care. When the average industry occupancy rate is at or above 95 percent, finding appropriate beds for patients can be difficult. Medicaid patients and patients with heavy care needs may suffer discrimination. In some states there are large backlogs of patients in hospitals awaiting nursing home placement. It costs a great deal more to pay for hospital stays than to finance the more appropriate nursing home care. In such a "seller's market" the facility can essentially choose which patients to admit because beds are in short supply. Private pay patients and patients with lighter care needs may be preferred.

To tackle this problem, some states have implemented a case mix reimbursement system for Medicaid patients. Such a system provides higher reimbursement rates for patients with heavier care needs so there is an incentive to accept these patients. Other states enact laws designed to prevent Medicaid or heavy care patients from discrimination. In some states separate waiting lists for private pay patients and Medicaid patients are outlawed. In two states there is an "equalization law." If a facility is certified for Medicaid, it cannot charge private patients more than it charges Medicaid patients. This slows down the "spend down" process. Facilities may, however, take only private pay patients and charge higher rates.

In many states where Certificate of Need has been repealed without employing a moratorium or other restrictive mechanism, there has been considerable growth in the long term care bed supply and a corresponding decrease in occupancy. Low occupancy rates increase the per patient cost of providing care. An exception is New Mexico where low reimbursement for capital expenditures and an imputed occupancy have kept overbuilding in check. Freezing the property reimbursement rate at the 1981 level in Utah, however, has not seemed to discourage growth. The result of overbuilding is increased pressure to fill beds and to raise Medicaid rates. Just as in Utah, market forces have not come into play quickly following the repeal of CON in other states.

In Arizona there was rapid long term care facility growth immediately following the repeal of CON. According to Hazel Chandler, Arizona Department of Health Services, recently there have been four total bankruptcies in nursing homes, four facilities have closed due to financial difficulties, and another four have been closed due to licensure difficulties (which she believes had their roots in financial difficulties). Occupancy rates in Arizona have now increased. They were 68 to 70 percent a year ago, and are now 80 to 82 percent. Ms. Chandler believes the rate will reach 90 percent by this time next year and that the industry will stabilize.

At the opposite extreme, New York has a very formal, effective, CON program. The program was so effective, in fact, that some argue there is now an overall shortage of long term care beds. The long term care occupancy rate is over 95 percent. There is a backlog of hospitalized patients waiting for nursing home placement and 2,000 people are placed out-of-state. Similarly, Nevada, which has retained CON, has an occupancy rate of 96 to 98 percent, and has some patients placed in Utah.

A moratorium may be aimed at controlling the growth of Medicaid expenditures. In some states such a move is used to restrict institutional growth while more emphasis is put on home and community based care. For example, in Wisconsin when a facility closes, funding goes to individuals being cared for in the community.

A moratorium on construction or licensure is more effective than a Medicaid moratorium. In Minnesota, a Medicaid moratorium went into effect in 1983. Between 1983 and 1985, 1,000 new beds were built. In 1985, a moratorium on licensed beds was put into place; since then virtually no new beds have been built. In Wisconsin there was a moratorium on construction from 1981-83. Now there is an absolute cap on the number of long term care beds available. (The absolute number cannot increase beyond the 1983 level.) Wisconsin has seen a gradual reduction in the number of beds.

Texas has a moratorium on Medicaid contracted beds. Issuing the moratorium seemed to create a panic mentality. There were several conditions under which facilities could be granted an exception to the

moratorium: 1) adding ten new beds or ten percent of the total beds, 2) facilities granted CONs prior to September 1, 1985, 3) facilities with capacity of less than 60 licensed beds, 4) if the applicant had a previous Medicaid contract, or 5) if an applicant had demonstrated "substantial commitment" which included expenditures of \$25,000. The number of not approved beds under all of these exceptions totaled 17,432! There were so many exceptions granted, the moratorium was of little immediate use. Texas will not experience a "real" Medicaid moratorium until the loopholes are closed in 1989. Since the moratorium does not affect licensing, additional beds for private pay patients are still being built. The Texas experience demonstrates that is important to limit the number of exceptions to as few as possible.

EXHIBIT 7
DATE 3-3-89
HB 340

VIII. DIFFICULTIES WITH REINSTATING CON

While in place, the Certificate of Need program in Utah was successful in restricting the long term care bed supply. Between 1979 and 1983, there was a net increase of only 20 acute care beds along the Wasatch Front, and virtually no new long term care beds were approved. In 1983 and 1984, 99 new long term care beds were constructed. These were allowed due to the adoption of a "modified flat rate" reimbursement system for nursing homes.

CON programs that exist today vary widely by state and have differing goals and objectives as well as differing levels of power to make and enforce decisions. "Even after minimum Federal standards were enacted, there continued to be substantial variation among States in the scope of coverage, thresholds, review procedures, due process requirements and sanctions incorporated in their individual certificate of need programs."⁸ A major policy goal for such a review program is controlling health care costs. Other goals include "preserving quality of medical care and preventing geographic and income related maldistribution of institutional health services,"⁹ and to "reward and protect facilities that internally subsidize socially desirable but unprofitable lines of business such as indigent care."¹⁰

Since CON is a regulatory measure, it tends to have more support and be more successful in areas where the philosophy of government intervention has a strong foundation. This has not traditionally been the case in the state of Utah.

There are concerns with CON programs. Existing providers who already have a substantial market share may be able to sway the decisions of the planning agencies and use the process to protect their own investments. When major investments or new services require review, the health facility or provider that is awarded the certificate of need is virtually guaranteed a franchise. This may cause companies to submit "defensive proposals" for expansions or new services just to keep up with, or to hinder, potential competitors. "Applications may be filed as a means for preempting applications by competing institutions when, in fact, the applicant is not seriously interested in following through with the project."¹¹ Such moves increase the cost to the system and lengthen the review process.

⁸ U.S. DHHS, "Panel B. State CON Experience: Program Aims and Policy Issues." Certificate of Need Program Review February 1982, p. 9.

⁹Simpson, p. 1225.

¹⁰Simpson, p. 1225.

¹¹Andrew F. Coburn, "Deregulating Entry Controls in Health Care: A Cautionary Note," Presented at Main Health Care Association Symposium, "Competition vs. Regulation" September 10-12, 1986.

Another difficulty is that regulatory agencies may not be able to review thoroughly all projects, due to staffing and financial constraints. The program can be expensive and cumbersome for the state and for the applicant. Large, wealthy health care corporations can spend a considerable amount of money to prepare and defend requests. "A large and politically strong institution may easily convince an understaffed and underfinanced CON agency not to incur costs required to develop a compelling refutation. Accordingly, the agency will adopt the path of least resistance, that is approval."¹² Even if denied, those with the resources are able to zealously pursue the appeal process. In the case of competing applications, or batched proposals, the appeal process may drag on for years. This leaves smaller health care institutions, without the financial and time resources to wage a major legal battle, or groups lacking political clout at a disadvantage.

At this time, memories of the earlier difficulties with the CON system are still fresh in Utah. The process was becoming longer and more complex. It was generally perceived as effective in controlling bed supply but less effective in other areas. The term "Certificate of Need" still engenders the memory of a program disliked by many, making it difficult to reestablish such a program.

If a capital expenditure review program is to be reinstated in Utah in the future, it would have to be less cumbersome and expensive than the previous CON system. The criteria used to determine the number and location of beds would need to be explicit and fair. Once a decision, based on the bed need criteria, is made, there should be no provision for appeal of the decision, only appeals based on the procedures followed in the course of review. It would also have to be simplified so that it would not be too expensive for the state or for the applicant.

Currently there are 12 states with no capital review program in place: Arizona, California, Colorado, Idaho, Kansas, Louisiana, Minnesota, New Mexico, South Dakota, Texas, Utah and Wyoming. Indiana dropped CON review for hospitals but retained the program for nursing homes. Texas currently has a moratorium on new Medicaid certified long term care. South Dakota implemented a moratorium on licensing new nursing home beds which coincided with the July 1, 1988, sunset date of CON. Louisiana had never had a CON program, but at the time of this writing a CON program had passed the House and Senate in Louisiana and was awaiting the Governor's signature. The program would apply only to nursing homes.

Beginning in 1983, the Utah Department of Health set forth a policy to promote price competition to control the health care market. It was estimated by most economists that 6 to 11 years would be needed to

¹²David S. Salkever; and Thomas W. Bice, "The Impact of Certificate of Need Controls on Hospital Investment." Milbank Memorial Fund Quarterly/Health and Society (Spring 1976): 190.

EXHIBIT 7
DATE 3-3-89
HB 340

establish the necessary market conditions. Before a capital expenditure review program is reinstated, this new policy should be given time to work and its effectiveness in controlling the market should be evaluated. Once this has been done, it may be appropriate to reinstate capital review statewide, or in the areas where the market is not effective. The competitive policy should not be abandoned, however, until it has been given a fair chance to develop.

IX. STRATEGIES TO BE EXAMINED

Any strategy to influence current conditions should have the objective of controlling cost while assuring access and high quality care for Medicaid patients.

The first option is simply to do nothing. If the current pattern is extended into the future, a likely scenario is as follows: the number of long term care beds will continue to grow, average occupancy rates will continue to decline, per unit costs will continue to rise, some nursing homes will be forced out of business, patients will have to be relocated, and the quality of care will decline. Access to care for patients will probably continue to be very good because nursing homes will need to fill empty beds. Empty beds may also allow Medicaid to provide only minimal increases in the flat rate.

A second course is to inject competitive forces into the market to foster price competition. Medicaid could contract only for the number of beds needed and allow nursing homes to submit their best bids. If such a strategy were to be followed, it would be extremely important to specify the minimum standards of care required. This strategy should serve as a signal to the industry that Medicaid will not support continued growth.

The third direction is to return to a regulatory measure, such as CON or a moratorium, to check the unrestrained growth. This would allow time for the demand for beds to catch up to the supply. There are difficulties in reinstating a capital review program like CON. The Health Systems Agencies have been dismantled. Policy makers in Utah do not favor government regulation, and past experiences with CON have left negative perceptions of this program.

The most effective strategy to handle the situation in the long term care industry is to give the industry relief from the incessant construction while assessing the feasibility of price competition. The market, as suggested by the Peat Marwick study, may need some time to stabilize. The first step is to place a Departmental moratorium on new construction or conversion of beds until the next legislative session. During this period the Department could design a competitive bidding experiment. The experiment will take place in a limited area and only involve Medicaid patients newly admitted to nursing homes. It would be designed to see if price competition in the long term care market can control cost while assuring access and high quality care for Medicaid patients.

During the legislative session a moratorium on the construction of, or conversion to, skilled and intermediate care beds could be passed. A legislative moratorium on construction and the competitive bidding project would go into effect at the same time. The moratorium would restrict new facilities from entering the market to halt the decline of occupancy rates.

Under the moratorium, only projects which had approved architectural plans and evidence that they had funded construction contracts prior to the date of the Department-initiated moratorium would be allowed to complete their projects under an exception to the moratorium. Nursing home beds proposed, built, or converted after that date would not be approved, licensed, or certified to care for long term care patients. This is to prevent corporations or individuals from "clipping in under the wire."

The rural swing bed program, which originally allowed hospitals with 50 or fewer beds to temporarily convert a few beds to provide long term care under Medicare, should be exempt from the moratorium. The program will be extended to include hospitals with up to 100 beds. Further easing of the requirements for "swing beds" should be carefully watched, however. It is important to assess whether the program is extending to the point where "swing beds" are substituting for nursing homes. If this happens, swing beds also should be included under the moratorium. Conversion of beds in general acute care hospitals, psychiatric hospitals, and other specialty hospitals to provide long term care should be included under the moratorium.

An integral portion of the plan is the implementation of a pilot project in competitive bidding. It may be necessary to apply to the federal government for a waiver of the freedom of choice requirement. This should be done as soon as possible.

The Department of Health also needs to begin collecting data on new admissions to nursing homes, to determine how many beds for which to contract initially. The Department will want to contract with the top ranked bids based on quality of care and price. The department will contract only for the number of beds needed in the area for the pilot project, so that the contracting providers will be assured of high occupancy rates. Currently the Department does not maintain records on the origin of new admissions. Patients may be readmitted for a number of reasons, including excessive leave of absence, hospital stays, change of ownership of the facility, and roll over to Medicaid coverage. There is currently no distinction made between admissions which are actually readmissions, and admissions of patients who are new to the system. These data will be needed before the actual number of contract beds can be determined. A conservative estimate of the number of new admissions by county should be made, based on the data collected. This information will then be available in time to send out the requests for proposals.

The number of patients involved in the project should be large enough to assure high occupancy rates for the facilities which successfully bid for the beds but not so large that the facilities not participating in the project are affected dramatically. The fall in occupancy in nonparticipating homes should be halted by the effect of the moratorium and by allowing some new Medicaid patients to be admitted. Nonparticipating facilities will be able to maintain current patients and also accept private patients, patients supported by Medicare, and patients not assigned to the demonstration project.

The pilot project also needs to take place in an area with a reasonable number of facilities. If the project were restricted to an area with only a handful of nursing homes, certain homes would be singled out for failure if their bids are not successful. A large enough number of nursing homes needs to be included so that the impact of the project will be to allow the nonparticipating facilities in the area of the project to retain current occupancy rates and to allow for occupancy to increase slowly over the next few years. A slow increase in occupancy should also occur in areas outside the pilot study. Facilities participating in the pilot study will increase their occupancy rates more quickly. A possible location for the pilot project would be Davis and Weber counties. Patients with a legal residence in these counties should be randomly assigned to either the demonstration project or a control group. A percentage of patients large enough to increase occupancy in the number of top bidding facilities would then be assigned to the pilot project. Those not assigned could enter a facility of their choice.

The freedom of choice waiver may not be needed if facilities which either do not bid or are not awarded a contract are allowed to participate at the awarded rate if they can assure the same level of quality. If this approach is chosen, it may be possible to include a greater percentage of new admissions in the project.

Before the project and the legislative moratorium go into effect, the Department of Health would issue Requests for Proposals, based on the Maricopa County, Arizona, model, with modifications for the structure of the present system in Utah. Facilities which provide intermediate and skilled nursing care would be allowed to bid. Intermediate care facilities for the mentally retarded (providing care levels of IMR-1, IMR-2, and IMR-3) will be excluded from the pilot project. The levels of care to be bid on will be: SNF-2, ICF-1, and ICF-2. Facilities participating in the project may also provide SNF-1 level care, but it will be excluded from the demonstration and the payment will be individually negotiated as it has been in the past.

Proposals should not be accepted from facilities where there is a history of major and substantiated violations of patient care standards, if this history can be verified, nor from those institutions with very poor facility survey track records. The type and maximum number of deficiencies allowed in the last two surveys will be specified to assure a level of high quality care. For example, if a skilled facility has had deficiencies in two conditions of participation in the last two surveys, a decertification action or an intermediate sanction reported in the last two surveys, it will not be allowed to participate. Complaints should also be investigated, and an excessive number of substantiated complaints should also exclude providers from participating in the project. It is important to keep in mind that the project must be designed to encourage price competition at an acceptable level of quality. Bids received which are below what is reasonable to provide acceptable care should be rejected.

Separate from the Department, a Ceiling Rate Committee should be established. This committee will be independent of the Department of Health, so that it is clear that the Department is not setting rates for the project. The Committee members should include individuals with expertise on nursing home costs and accounting, but should not be affiliated with any nursing home. The committee will establish ceilings for reasonable charges for care. Facilities bidding below the ceilings should be given preference.

The evaluation and selection of facilities by the Department should be final and not subject to review. The Department may reject any and all proposals submitted in response to the Request for Proposal. Contracts for those facilities successful in the bid will be finalized to coincide with the legislative moratorium.

If the number of new patient admissions (not included in the exceptions) exceeds the number of beds available in contracting facilities, the Department will then complete contracts with a facility or facilities ranked next according to the quality and price guaranteed in their bids.

The Department of Health will monitor each facility's compliance with and performance under the contract. Either party may terminate the contract with 90 days prior written notice. The Department will have the right to terminate the contract upon 24 hours notice if it deems that the health or welfare of a patient is endangered.

When the project begins, all new admissions will be screened to see if the patients should be included in the project. Several categories of patients will be excluded: patients who had previously financed their care privately but now qualify for Medicaid, patients who were Medicaid supported in a facility but had to be readmitted due to a hospital stay or an excessive leave of absence, and patients transferring from one nursing facility into the demonstration site. If the patient is to be included in the pilot project, she or he would be randomly assigned to the control or the experimental group. If a patient is assigned to the experimental group, she or he will be given the choice of any of the facilities which were successful in their bids and have completed contracts with the Department. If assigned to the control group, the patient will be able to choose any facility certified by Medicaid.

The preadmission screening process and continued stay review currently required for all Medicaid patients will also be required for all patients in the project. Facilities outside the geographic area of the project and those which either did not bid or were not chosen to participate in the project will continue to be reimbursed under the Medicaid flat rate.

The pilot project and the moratorium should be evaluated annually. The effect of the moratorium, its success in preventing construction, and its impact on access to care should be reviewed. If necessary,

amendments or revisions should be proposed. The pilot project should be examined to determine if it is cost effective for Medicaid, if high quality care standards are being maintained, and if access to care for Medicaid patients has been safeguarded. Patients, families of patients, and advocates of patients in both the experimental and control groups should be surveyed about their perception of care, and the results should be compared. Evaluations of care standards should be conducted by the Department. If necessary, changes in policies or procedures should be recommended. The impact of both moves on the Medicaid budget should also be assessed.

After two years, both the demonstration and the moratorium should be examined to determine if market forces are in place. If so, the moratorium should be discontinued. The moratorium should remain in place if market forces are not yet present. Evidence that competitive forces are in place include: (1) the extension of competitive bidding to the entire Medicaid system, or (2) use of selective contracting or competitive bidding by another payer such as a carrier of private long term care insurance.

If, at any time, average industry occupancy rates are at or above 92 percent for three consecutive months, the moratorium should be removed. If the competitive forces fail to take root, the moratorium would have a sunset date in six years regardless of the prevailing market conditions. If the moratorium has successfully prevented building, by this time the projected demand for beds should have caught up with supply.

If it is determined that the moratorium and competitive bidding project are to continue, the Department will again submit Requests for Proposals. If a facility which participated in the first part of the project does not participate in the continuation, patients in the facility will be given the choice to remain in that facility or to be relocated. If a patient chooses to remain in the facility, reimbursement will be made consistent with that for Medicaid patients not participating in the project. Periodically, patients in noncontracting facilities should be canvassed to determine if they would be interested in moving to a lower cost facility. The project should not be discontinued without also lifting the moratorium. Lifting of the moratorium, however, should not necessarily end the competitive bidding project.

This demonstration will foster the development of competitive forces. It includes a small experimental group of facilities which receive contracts for new admissions, while retaining the traditional Medicaid payment mechanism for the control group. It also allows the projected need for long term care beds to catch up to the current supply through a moratorium on new construction.

X. NEED FOR ADDITIONAL INFORMATION

No matter what strategy the Department follows, there is an increasing need for accurate information about the long term care environment to be collected, analyzed and made public. It is important to gather, maintain, and analyze demographic data. Projections of the number of long term care beds needed in the future should be made, based on historical utilization of specific groups. These projections should take into account the growing proportion of the population over age 85, the number of elderly living alone, the changing social environment (more women in the work force which makes them less available to care for elderly relatives). The main factors which lead to institutionalization including a high level of functional disability and the loss or absence of informal support in the community such as spouses and children.¹³ The projections should be made available to the public and to potential developers after a moratorium is lifted.

The Department must also collect information on admissions to nursing homes, including patient origin and destination, previous nursing home and Medicaid utilization, and level of care.

The Department of Health already collects information on occupancy rates of nursing homes. This information, too, should be made available to potential developers. After the moratorium is lifted, the State should require any developer who wants to build a new nursing home, increase or decrease bed capacity, or convert beds from or to any long term care use, to give written notice. Included should be a very brief description of the project (number of beds) and a cost estimate. This information should also be made available to the public.

¹³Judith R. Lave, "Cost Containment Policies in Long-Term Care," Inquiry 22 (Spring, 1985): 11.

XI. ADDITIONAL RECOMMENDATIONS

An area of serious concern is the nursing shortage. It is increasing the cost of providing care, raising concerns about quality of care, and increasing the stress on already overworked nurses. Such stress multiplies the burnout rate and makes the profession less attractive to potential nurses, further exacerbating the shortage. In confronting this issue, there are several areas where improvements are needed: the image of the nursing profession, opportunities for advancement, working conditions, recognition for achievement, and relationships with administrators and physicians. Overcoming these difficulties goes beyond the scope of this paper. However, encouraging projects between nursing schools and nursing homes may help to ease the difficulty of long term care facilities in attracting nurses. In addition, Utah is the only state in the nation where the applicants to nursing school exceed the number of slots available. Increasing funding to nursing schools and providing incentives to increase enrollment are important first steps toward a long range solution.

Even though the Medicaid program is likely to remain the dominant buyer of long term care services in the future, the State should still support the development of private financing alternatives. Nationally, approximately 20 percent of all elderly will be in nursing homes for some period of time. Since the risk of needing long term care is spread evenly over the population, it is logical to pool the risks of needing such care through the use of long term care insurance.

Private long term care insurance would allow individuals to contribute a small amount over time to protect themselves against the eventuality of needing long term care. Availability of such insurance could slow the rate of increase in spending on long term care by Medicaid. In order to make purchasing long term care insurance attractive, the state must first educate residents of Utah about the potential need for long term care. Many people still believe that Medicare, Medigap, or private insurance will cover the costs of a long term nursing home stay. In reality, these sources account for less than three percent of the payment for long term care! People must also be encouraged to purchase policies at a young age, so the policies will be affordable. Objective consumer information about available long term care policies must then be made public. Some long term care policies now available are fixed in both premiums and pay out. Although a pay out rate of \$35 a day may help to cover the cost of a nursing home stay in 1988, when the typical individual would need the coverage in the year 2010, when the daily charge could have increased to \$450.¹⁴ Such a benefit does little to cover the future cost of care. The State should

¹⁴Timothy M. Smeeding, and LaVonne Straub. "Financing Retiree Health Care: Who Pays What and When?" Prepared for the Southern Economic Association Meetings, New Orleans: November 1986.

sponsor an educational campaign highlighting the potential need for long term care, the lack of financing by other payors, and the factors to consider in purchasing long term care insurance policies.

Innovative ways to provide and finance long term care will be needed for the State to cope with the challenges of an aging population. New ideas and demonstration programs should be investigated. Currently there are demonstration projects underway to test the innovative idea of a Social Health Maintenance Organization (S/HMO). It is worthwhile to investigate developing such a program in the state of Utah. All aged, blind, and disabled Medicaid recipients could be enrolled in such a program. S/HMOs would take responsibility for acute, home health, nursing home, and other social and medical services. The S/HMO would be paid on a capitation basis. As an HMO it may be able to establish contracts with hospitals and nursing homes to purchase care at a discount. The success or failure of the demonstration projects in other states should be monitored. There are several obstacles to be overcome in establishing such a program which makes it a long range solution.

XII. BIBLIOGRAPHY

- Ad Hoc Committee on Certificate of Need. "An Evaluation of the Michigan Certificate of Need Program." February 19, 1987.
- American Health Care Association "Eliminate Restrictions on Labor Costs for Nursing Staff." Issue Paper.
- American Health Care Association, "Reauthorize Nurse Education Act." Issue Paper.
- Blake, Diane. "Nurse Shortage Has Broad Implications." Pro Re Nata 10 No. 2 (March/April 1988).
- Brich, Heidi M. An International Perspective on Long Term Care for the Elderly unpublished Honors Thesis.
- Brown, Lawrence D. "Common Sense Meets Implementation: Certificate of Need Regulation in the States." Journal of Health Politics, Policy and Law 8 No. 3 (Fall, 1983): 480-494.
- Burda, David. "Hospital Construction Boom not Expected Despite End of Some State CON Programs." Modern Healthcare (November 6, 1987): 134.
- Cherskov, Myk. "Hospitals Hurdle CON Barriers Differently." Hospitals (May 20, 1986): 89.
- Cherskov, Myk. "Planning Agencies' Futures, Funds Uncertain." Hospitals (June 20, 1986): 79-80.
- Christianson, Jon B.; Hillman, Diane G.; and Smith, Kenneth R. "The Arizona Experiment: Competitive Bidding for Indigent Medical Care." Health Affairs: 87-103
- Coburn, Andrew F. "Deregulating Entry Controls in Health Care: A Cautionary Note." Presented at Health Care Association Symposium, "Competition vs. Regulation" September 10-12, 1986.
- Feder, Judith; and Scanlon, William. "Regulating the Bed Supply in Nursing Homes." Milbank Memorial Fund Quarterly/Health and Society 58 No. 1 (1980): 54- 88.
- Friedman, Emily. "Medi-Cal Contracting: Model or Mayhem?" Hospitals (August 1, 1984): 74-78.
- Friedman, Emily. "When the Mainstream Becomes a Trickle." Hospital Forum (July/August): 9-17
- Freudenheim, Milt. "Nursing Homes Face Pressures that Imperil Care for the Elderly." New York Times Saturday, May 28, 1988.

- Greenberg, Jay N.; Leutz, Walter; Ervin, Sam; Greenlick, Merwyn; Kodner, Dennis; and Selstad, John. "The Social/Health Maintenance Organization & Long Term Care." Generations (Summer 1985): 51-55.
- Hekman, Ellen L. "State Efforts At Health Care Cost Containment." National Conference of State Legislatures September, 1984.
- Heller, Gloria; and Chase, Mary. "A Study of the Impact of Health Care Deregulation on Hospitals, Nursing Homes and Health Services in Arizona." November 15, 1985.
- Howell, Julianne R. "Evaluating the Impact of Certificate of Need Regulation Using Measures of Ultimate Outcome: Some Cautions from Experience in Massachusetts." Health Services Research 19 No. 5 (December, 1984): 587-613.
- Illinois Health Care Cost Containment Council. "Report of the Illinois Health Care Cost Containment Council to the Governor and the Illinois General Assembly on the Effectiveness of Certificate of Need Review." October 27, 1987.
- Intergovernmental Health Policy Project. "Health Issues Affecting the Elderly." January, 1987.
- Kinzer, David. "The Decline and Fall of Deregulation." New England Journal of Medicine 318 (January 14, 1988): 112-116.
- Kolb, Deborah S.; and Krueger, Deborah J.; "Controlling Expansion of the Nursing Home Industry: Effects of Prospective Payment Systems on Capital Formation." Topics in Health Care Financing (Spring, 1984): 77-89.
- Larkin, Howard. "Deregulation Spurs Market Information Demand." Hospitals (December 20, 1987): 58.
- Lave, Judith, R. "Cost Containment Policies in Long-Term Care." Inquiry 22 (Spring, 1985): 7-23.
- Legislative and Budget Finance Committee. "Report on a Study of Pennsylvania's Certificate of Need Program." February, 1987.
- Luke, Ronald T. "Elimination of Determination of Need Regulation of Psychiatric Hospitals in Indiana." February, 1987.
- Luft, Harold S. "Competition and Regulation." Medical Care 23 No. 5 (May, 1985): 383-399.
- National Governors' Association. "State Long Term Care Reform: Development of Community Care Systems in Six States." April, 1988.

- Neuschler, Edward. "Medicaid Eligibility for the Elderly in Need of Long Term Care." Health Policy Studies, National Governors' Association. September, 1987.
- Pierce, Robert M. "Major Health Issues for States: 1986." Presented to the National Conference of State Legislatures, February, 1986.
- Peat Marwick, Study of the Nursing Home Profitability for the Nursing Home Industry in the State of Utah December, 1986.
- Popko, Kathleen, SR; and Patrick, Laskey, W., SR. "The Social/HMO: Is it Feasible in a Community Hospital Setting?" Hospital Progress (October, 1987): 50-53.
- Rivlin, Alice M.; and Wiener, Joshua M. "Who Should Pay for Long-Term Care for the Elderly?" The Brookings Review (Summer, 1988): 3-9.
- Salkever, David S.; and Bice, Thomas W. "The Impact of Certificate of Need Controls on Hospital Investment." Milbank Memorial Fund Quarterly/Health and Society (Spring 1976): 190.
- Schramm, Carl J. "Revisiting the Competition/Regulation Debate in Health Care Cost Containment." Inquiry 23 (Fall, 1986): 236-242.
- Scott, Denman H.; Tierney, John T.; Waters, William J.; Williams, Donald C.; and Donahue, John X. "Certificate of Need: A State Perspective." Rhode Island Medical Journal 70 (August, 1987): 341-345.
- Shain, M.; and Roemer, M. Hospitalization Under Insurance (Chicago: American Hospital Association, 1959).
- Shortell, Stephen M.; and Hughes, Edward F.X. "The Effects of Regulation, Competition, and Ownership on Mortality Rates Among Hospital Inpatients." The New England Journal of Medicine 318 No. 17 (April 28, 1988): 1100-1107.
- Simpson, James B. "Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control." Indiana Law Review 19 No. 4 (1986): 1025-1127.
- Simpson, James B. "State Certificate of Need Programs: The Current Status." American Journal of Public Health 75 No. 10 (October, 1985): 1225- 1229.
- Sinclair, Sara V. "The Licensed Nursing Shortage in Nursing Homes." Presented to the National Commission on Nursing, New Orleans: April 15, 1988.

Smeeding, Timothy M.; and Straub, LaVonne. "Financing Retiree Health Care: 'Who Pays What and When?'" Prepared for the Southern Economic Association Meetings, New Orleans: November 1986.

Thomas, Constance. "State Health Notes." Intergovernmental Health Policy Project No. 67 (October, 1986): 1-12.

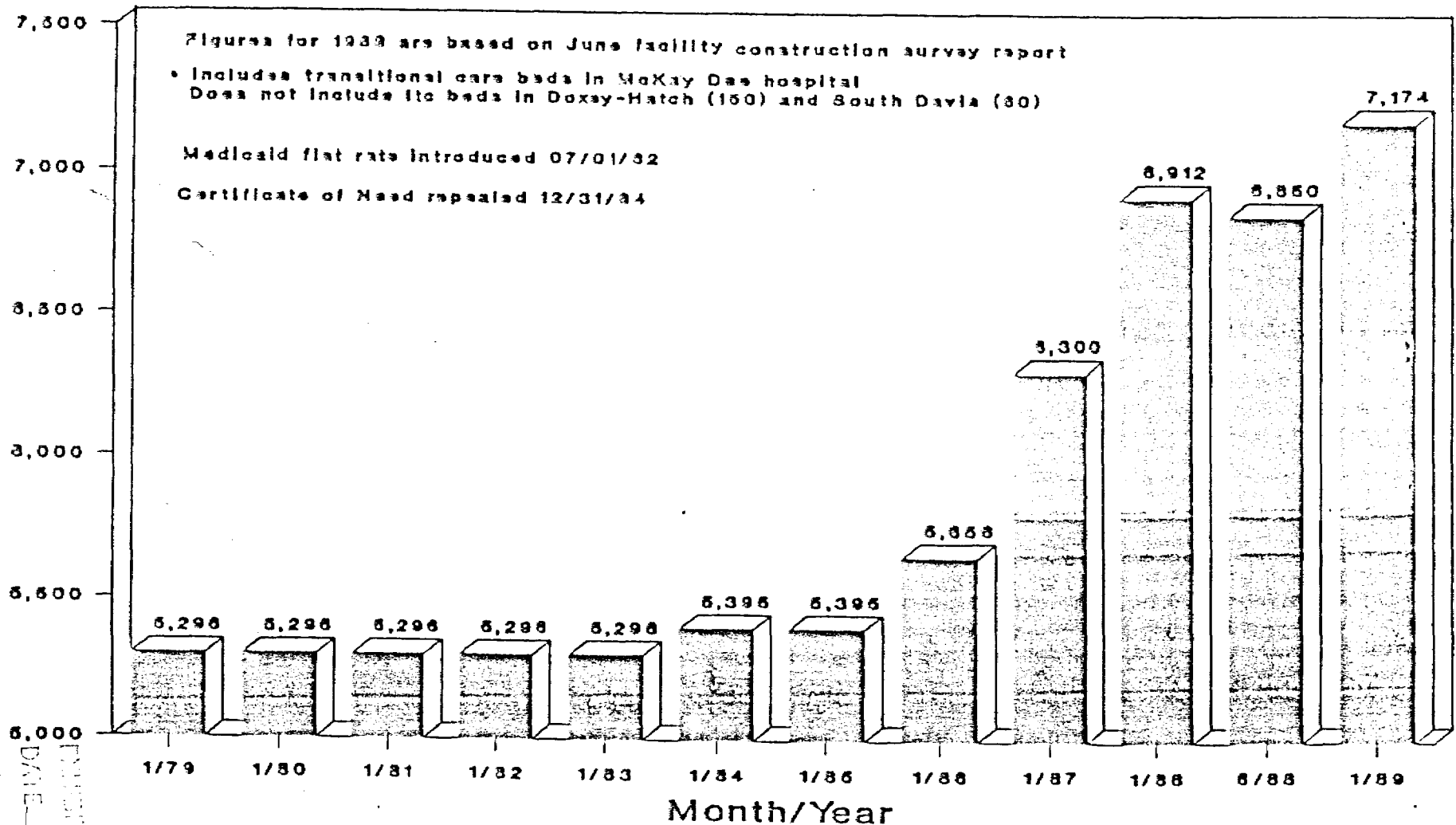
Utah Department of Health. A Statement of Health Policy: A Prescription for Health Care Costs in Utah February, 1983.

United States Department of Health and Human Services. "The Availability of Nursing Home Beds for Private Pay Patients and the Certificate of Need Issue." HCEA May 18, 1987.

United States Department of Health and Human Services. "State CON Experience: Program Aims and Policy Issues." Certificate of Need Program Review February, 1982.

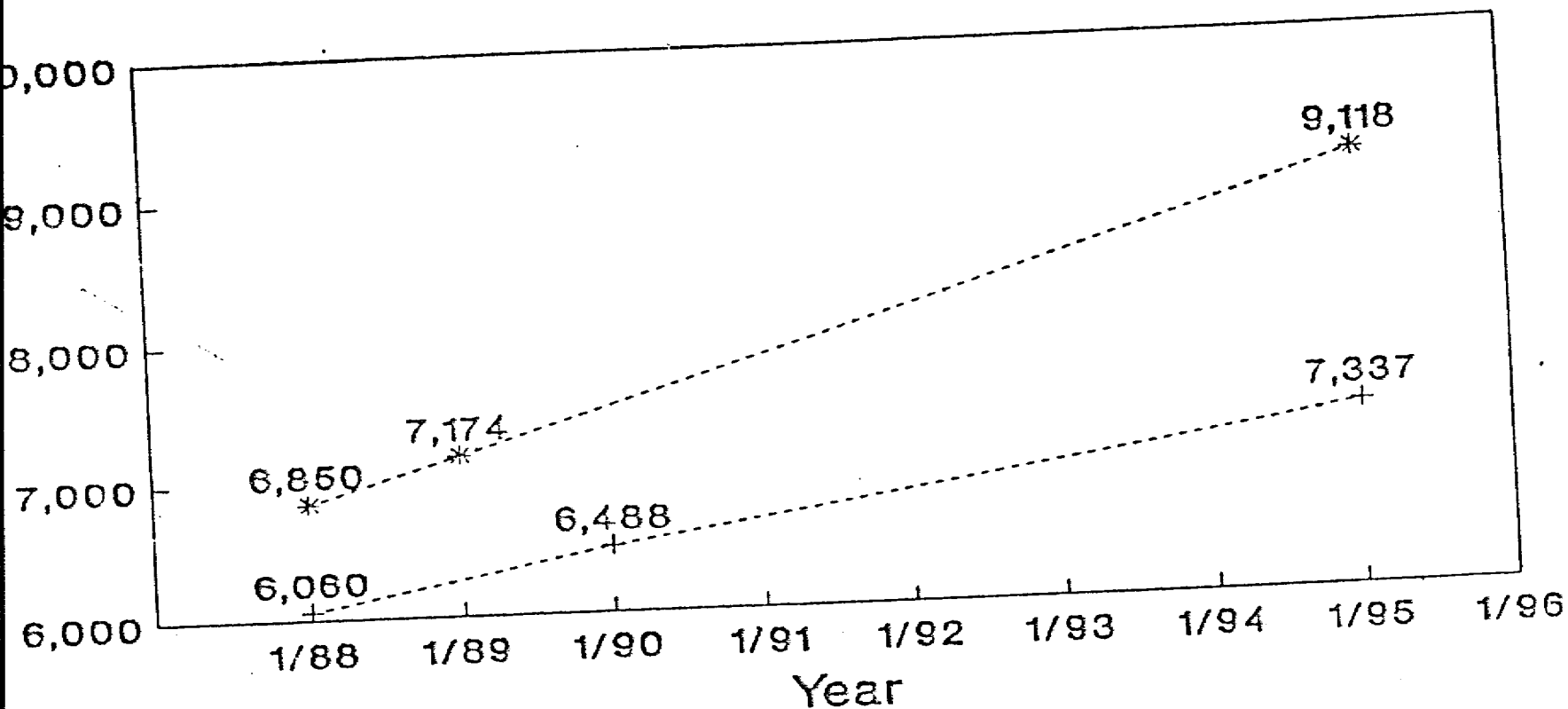
United States General Accounting Office. "Health Care Facilities: Capital Construction Expenditures by State." August, 1986.

Net Change in Geriatric Beds



HB 340
DATE 3-3-89
PAGE 7

Projected Number of Beds Required for those 65 and Older



--*-- Actual Licensed Beds --+-- Projected Bed Need

Based on historical utilization rates and 90% occupancy.

9140 Signature

We, the undersigned, do hereby support the passage of SB 346 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE

PRINTED NAME

ADDRESS

Cindy K. Leonskrecht	Cindy K (Eiams) Leonskrecht	611 Sapphire Blgs MT 59105
Walter R. Schenker	Walter R. Schenker	716 North 1st St. Billings
K P Lucien	K P LUCIEN	1132 Ave. F Bldg Mt
Shawna McBride	Shawna McBride	3121 10th Ave N Bldg MT 59
Jerry Stigler	Jerry Stigler	5543 Creek Billings MT
Marguerite Gault	Marguerite Gault	2600 Terrace Dr. SE
Katherine Maurakis	Katherine Maurakis	135 Burlington Bldg MT
Gus Maurakis	GUS MAURAKIS	135 Burlington Bldg MT
Donna Leone	Donna Leone	1298 Jefferson
Vera Reinke	Vera Reinke	1724 Mariposa
Lyle Hartman	Lyle Hartman	4 Redwood Place Bldg - 591
Ann Gerhart	Ann Gerhart	3342 N. Janey
Ralph Pelison	Ralph Pelison	Elmer Creek RT 59101
Ann Gerhart	ANN GERHART	3307 Spruce St.
Rose Goultanis	Rose Goultanis	1125 W. 26th
Lydia Reser	Lydia Reser	1039 Enterprise St. MT 59102
James E. Milligan	JAMES E. MILLIGAN	1635 Bitterroot Dr. 5910
Lee R. McDannell	Lee R. McDannell	2315 Colton Bldg - 13193 MT 59102
Mervin H. Crick	Mervin H. Crick	5010 Rimrock Rd 5910
Helmer Haggensen	Helmer Haggensen	1342 Canary 59101
Joe P. Besso	JOE P BESSO	1913-17th St West
George P. Lensty	George P. Lensty	1025 Howard Ave Bldg
Ruth Larson	Ruth Larson	1935 Lake Elm Dr.
J. E. Fry	J. E. FRY	1746 Parkview Dr.
Virginia Larson	Virginia Larson	4 Redwood Place
Donna Dark	Donna DARK	City Mt.
Donna Dark	Donna DARK	1355 Blvd. Condo. Bldg. MT 5910
Vernon A. Dasehl	Vernon A. Dasehl	2010-16th Ave Billings MT 59107
Karl Bittner	Karl Bittner	2115 George St Billings
Ullrich Hume	Ullrich Hume	2206 Hume Bldg
Steve Lee	Steve Lee	769 Yellow Pine #30 Billings 59103

PETITION

Page 2 of

We, the undersigned, do hereby support the passage of SB 3410 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<i>Paula Sue Doudle</i>	Paula Sue Doudle	2311 Spruce Blgs 5th
<i>Tamara M. Valdez</i>	Tamara M. Valdez	230 Ave E
<i>Mary C. Bennett</i>	Mary C. Bennett	2319 1/2 Bellman #4
<i>Sara Burnett</i>	Sara Burnett	312 Adams
<i>Kent P. Keller</i>	Kent P. Keller	5206 Rimrock Rd
<i>John M. Hanson</i>	John M. Hanson	1802 Lilly Hts
<i>Boeth E. Dahlin</i>	Boeth E. Dahlin	409 Caravan Ave.
<i>Sam W. Rappie</i>	Sam W. Rappie	514 Clark Ave
<i>J. Kevin Stepek</i>	J. Kevin Stepek	3849 Blackhawk Dr
<i>Curt L. Allen</i>	Curt L. Allen	431 Custer
<i>Rick S. Fford</i>	Rick S. Fford	4950 Thornton Rd Blgs m +
<i>David Schulte</i>	David Schulte	325A FRANKER Av. E. HL-4
<i>Diana Gierke</i>	Diana Gierke	1831 Yellowstone Bldg
<i>Vicki Harvey</i>	VICKI HARVEY	1119 N 31st BILLINGS
<i>Ram Thomas</i>	Ram Thomas	1122 GOVERNORS Blvd
<i>Clarence M. Zent</i>	Clarence M. Zent	918 N. 30th ST - Blgs
<i>Karen A. Plavadtchen</i>	Karen A. Plavadtchen	620 Rockcliff Dr. Blgs
<i>Evelyn Zent</i>	Evelyn Zent	918 No. 30th St - Blgs
<i>Doreen Amundson</i>	Doreen Amundson	541 Resolution Ave
<i>Mary K. Hsod</i>	Mary K. Hsod	3923 2nd Ave S. Blgs
<i>Barbara L. Harvett</i>	Barbara L. Harvett	1639 Clark Ave 3lp
<i>Bobbi J. David</i>	Bobbi J. David	5800 Hwy 87 N.
<i>DANIEL A. TATARON</i>	DANIEL A. TATARON	805 YELLOWSTONE AVE BLGS
<i>Laurie J. Rudin</i>	Laurie J. Rudin	719 Archer #6 Blgs
<i>Pamela J. Bailey</i>	Pamela J. Bailey	912 CLISTDR. Blgs 5th
<i>Brett Culver</i>	Brett Culver	1108 Fredrick Ln.
<i>Dan Holtjorn</i>	Dan Holtjorn	1023 N. 31st Blgs.
<i>Nancy Graf</i>	NANCY GRAF	903 PRINCETON BILLINGS
<i>Don Doudle</i>	Don Doudle	2311 Spruce Blgs 5th
<i>Geraldine Crousch</i>	Geraldine Crousch	3828 Highland P. Bill.
<i>Jack W. Chapman</i>	JACK W. CHAPMAN	1413 Ave E. Blgs m

We, the undersigned, do hereby support the passage of SB 310 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

My witness
initials X

SIGNATURE	PRINTED NAME	ADDRESS
<i>Per. John J. Lincoln</i>	Don Lady of Guadalupe	523 29 th St. Billings
<i>Jack Brown</i>	Jack Brown	374 S. Yellowstone, Billings
<i>Ray H. Walsh</i>	RAY H. WALSH	5230 AVE B BILLINGS
<i>Valburga Walsh</i>	VALBURGA WALSH	3230 6th St. Billings
<i>Agnes Miesalaski</i>	Agnes Miesalaski	718 No Newton Billings
<i>Phyllis J. Wolf</i>	Phyllis J. Wolf	550 3rd St. S. Wolf Point MT 59701
<i>Shirley Bugard</i>	Shirley Bugard	3249 South Circle - Billings 59105
<i>Eva Riddinger</i>	Eva Riddinger	3323 - 4th St. S. Billings 59101
<i>Edna Schiff</i>	Edna Schiff	5 - 1st St. Billings
<i>Caroline Staley</i>	Caroline Staley	4834 Central Bldg
<i>Norma Kretz</i>	Norma Kretz	7428 Highland St. Billings 59114
<i>Diane Price</i>	Diane Price	8640 Gaugem Lane Bldg 59106
<i>Freda Endeburn</i>	Freda Endeburn	1432 4th St. C. Billings, MT
<i>William E. Wright</i>	William E. Wright	1515 Broadway, Sheridan, Wyo. 82801
<i>Natalie E. Wright</i>	Natalie E. Wright	1515 Broadway, Sheridan, Wyo. 82801
<i>Sister John Regis Lesser</i>	Sister John Regis Lesser	1241 N. 30th, Billings MT 59101
<i>Jane Schafer</i>	Jane Schafer	1111 3rd St. West Billings, MT
<i>Betty Stammen</i>	Betty Stammen	339 WICKS St. Billings
<i>Carol Ask</i>	CAROL ASK	210 Mt 208 Kalispell, MT
<i>Larry M. Stammen</i>	HARRY STAMMEN	2096 Orchard Way Billings
<i>Mildred Schindler</i>	Mildred Schindler	2146 Beloit Billings
<i>Maxine Schindler</i>	Maxine Schindler	2146 Beloit Billings
<i>Beth M. Tilton</i>	BETH M. TILTON	9003 Broadway, Helena, Bldg
<i>Betsy Britain</i>	BETSEY BRITAIN	2416 Elm St. Helena
<i>A. Katherine Doss</i>	A. Katherine Doss	1204 S. 1st St. Helena 59501
<i>Harriet Shuyler</i>	Harriet Shuyler	4114 Morgan
<i>Lois Tarek</i>	Lois Tarek	1346 Hawthorne Ln Bldg
<i>Harriet Scriber</i>	HARRIET SCRIBER	149 Erickson Ct
<i>Kim Canine</i>	KIM CANINE	2925 Kincaid Rd.
<i>Tropia Lester</i>	Tropia Lester	2917 Tarek
<i>Carol Atchison</i>	Carol Atchison	8 Dillman Rd, Roundup

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE

PRINTED NAME

ADDRESS

<i>[Signature]</i>	TOPI FINKELSTEIN	2111 1st St. SE
<i>[Signature]</i>	S. Frances Burt	2156 Redwood
<i>[Signature]</i>	KATHIE L. RIGGS	911 Poly, 59102
<i>[Signature]</i>	LINDA VARELA	P.O. Box 15 Bullantone St
<i>[Signature]</i>	Gary Engleman	2021 St. Johns - 59102
<i>[Signature]</i>	Pat Ellison	105 Shady Ranch 59102
<i>[Signature]</i>	DAVID G HEALOW	2525 IRVING PL 59102
<i>[Signature]</i>	CHADLEY STALEY	1607 21st West
<i>[Signature]</i>	RITA TURLEY	114 White Circle
<i>[Signature]</i>	Betty V. Miller	1109 Delphinium Dr. 59102
<i>[Signature]</i>	JAMES T. PAQUETTE	1109 Toulon St. B. House 59102
<i>[Signature]</i>	Jane Moore	215 Newell P. Billing 59102
<i>[Signature]</i>	Calen K. Northam	3034 Ave F. MT. 59102
<i>[Signature]</i>	TRICK FALGOUT	2411 Ring Olds Bldg. 59102
<i>[Signature]</i>	JENNIFER SMITH	1437 AVE E Billings 59102
<i>[Signature]</i>	J. K. ENGLEMAN	2021 St. Johns Bldgs.
<i>[Signature]</i>	LISA P. WOJTECH	112 Hilltop Bldgs. 59102
<i>[Signature]</i>	STEVE SHANDERA	2203 KINCAID RD
<i>[Signature]</i>	MIKE NICHOLS	2425 HOWARD Bldgs
<i>[Signature]</i>	Chere' Allan	2235 Dallas Bldgs 59102
<i>[Signature]</i>	SANDY STEPPER	3301 STONEWALL Bldgs
<i>[Signature]</i>	Cheryl Oliver	1294 yellowstone #4 59102
<i>[Signature]</i>	Reagan Litzsinger	833 Mesquite Bldgs 59102
<i>[Signature]</i>	Linda Olsen	P.O. Box 2011 Bldgs 59102
<i>[Signature]</i>	MARK A. BUZYNSKI	1132 DELPHINIUM
<i>[Signature]</i>	William J. Pfingsten	1690 Lockhills
<i>[Signature]</i>	Lindi Funston	1517 9th St W. Billings MT 59102
<i>[Signature]</i>	Kathleen Shaw	3107 South 18th St West
<i>[Signature]</i>	Deborah Kvale	3346 Racquet Drive
<i>[Signature]</i>	Bob HAZARD	4644 N. Woodhaven
<i>[Signature]</i>	Jill Penwell	1422 Colton - Billings

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
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Lynne Polly	Lynne Polly	3021 E. McDonald
Dorlene Wenzel	Dorlene Wenzel	21 Alamo
Jan Christensen	Jan Christensen	107 Wyoming Ave
Della Bender	Della Beth Bender	4331 Mitchell Ave
Linley Tingle	Linley Tingle	17 King Henry
Tammy Klien Rol	Tammy Klien Rol	1337 St Johns
Monica Weinert	Monica Weinert	536 Parkhill Dr
Karen Kolodny	KAREN Kolodny	4058 Riverside Rd
JEAN HOLDEN	JEAN HOLDEN	1029 3rd Ave
Carolyn M. West	Carolyn M. West	5334 Kelowna Dr
Sister Alice Mary Gorman	Sister Alice Mary Gorman	11-2788 Hyacinth
Janet A. Keller	Janet A. Keller	5200 Rimrock
Aileen Steward	Aileen Steward	155 Lake Elm Dr. Bldg 3
Marilyn E. Julian	Marilyn E. Julian	Box 1 Box 28 Sol.
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Milous REPKA	Milous REPKA	3315 Havluu
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SHARON TRIPP	SHARON TRIPP	626 Brookwood
Katherine E. Myers	Katherine E. Myers	710 Agate
Phyllis L. Ledesma	Phyllis L. LEDESMA	20 CHARLENE S
Deborah Sonn	Deborah Sonn	2501 Miles
Annette Fisher	Annette Fisher	517 Riverside
Candie Larson	Candie Larson	332 Phillip

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<u>Dan Boehler</u>	Dan Boehler	2441 Howard Billings
<u>David Perale</u>	David Perale	4413 Phillips St. Billings, MT
<u>Janet Wagner</u>	Janet Wagner	2794 Phyllis Circle So
<u>Jack Gallander</u>	Jack Gallander	2023 Lincoln 1895, MT
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<u>Blor. A. Lukie</u>	Blor. A. Lukie	1203 North 24th
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<u>Michael Howell</u>	Michael Howell	4803 Hazelcut Ave
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<u>Virginia A. Kern</u>	Virginia A. Kern	4304 So Heritage
<u>Sister Marian Berry</u>	Sister Marian Berry	1233 N. 30th St, Billings
<u>Sister Valerie M'Geough</u>	Sister Valerie M'Geough	142 Wyo. Ave. Bldg. 5
<u>Lynn Massey</u>	Lynn Massey	3806 Stadium Dr
<u>Dora May Abba</u>	Dora May Abba	3301 Stone Bldg, MT
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<u>Phil Tilley</u>	Phil Tilley	721 Cross Billings MT
<u>Evelyn Johnson</u>	Evelyn Johnson	2839 Chester St
<u>Sue BRADSHAW</u>	Sue BRADSHAW	702 Oak Billings
<u>Anne Sloan</u>	Anne Sloan	3616 Otis Lane
<u>Dr Vincent M'Kernan</u>	Dr Vincent M'Kernan	142 Wyo Ave Bldg 5

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE

PRINTED NAME

ADDRESS

Sister Jane Ellen Tunny	Sister JANE ELLEN TUNNY	Furn 1241 North 30th
Janet L. Olson	Janet L. Olson	415-56th St W Billings
Margaret Lubke	MARGARET LUBKE	27 W. 16th
Eleanor Shaw	ELEANORA SHAW	411 So. 31st St.
Sandy Jo Hobb	Sandy Jo Hobb	2232 Alhambra B. Billings
Dorothy Stroble	Dorothy Stroble	304 Alkali Cr. Rd. R7 " "
Margaret Fitch	Margaret Fitch	41408 Vaughn Ln. " "
Jenny Lee Hernandez	JENNY LEE HERNANDEZ	4440 MORGAN AVE Bldg. M
Kaye Clark	KAYE CLARK	21 Walnut Grove Bldg. 31
Jeanne Meeks	JEANNE MEES	2308 ELM ST. Bldg. M
Dolly Homme	DOLLY HOMME	416 Terry Ave. Bldg. M
Julie Larson	Julie Larson	103 Saddle Tree Pl. Bldg. M
Margaret Maggard	MARY M MAGGARD	1147 Yellowstone
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Marilyn Sulones	MARILYN SULONES	54 Shadow Pl
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Jeanne Lake	Jeanne Lake	3127 31st W Bldg. M
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Paul Hartman	PAUL HARTMAN	BILLINGS MT
Renee Sparkman	Renee Sparkman	1489 Rockwell Way
Deborah S. Tierney	Deborah S. Tierney	2304 22nd St W

59102

PETITION

Page 3

We, the undersigned, do hereby support the passage of SB 340 - the Certification Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON collection for hospitals only.

SIGNATURE

PRINTED NAME

ADDRESS

<i>Ellen E. Herringhouse</i>	ELLEN E. HERRINGHOUSE	4200 Hermosa Ln.
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<i>Constance A. Benner</i>	Constance A. Benner	521 Piney Circle
<i>Sharon A. Trivakala</i>	Sharon A. Trivakala	P.O. Box 21318
<i>Kathy Bouchie</i>	Kathy Bouchie	527 Grand
<i>Marie E. Reidt</i>	MARIE E. REIDT	800 Livingston E. Biggs
<i>Maude Dodge</i>	MAUDE DODGE	4444 Cleveland, Biggs
<i>Sylvia Duncan</i>	SYLVIA DUNCAN	615 NORTH 24th
<i>Joyce Fletcher</i>	JOYCE FLETCHER	723 Ave. C, Billings
<i>Rose Senn</i>	ROSE SENN	2419 6th Avenue
<i>Alice Kober</i>	ALICE KOBER	1039 N. 26 Street
<i>Jean D. Boyer</i>	Jean D. Boyer	2557 University Ave.
<i>Donald O'Neill</i>	Donald O'Neill	
<i>Marian O'Neill</i>	Marian O'Neill	909 Odessa St.
<i>Marie Sullivan</i>	Marie Sullivan	308 Wankasha
<i>Mary Jo Miller</i>	Mary Jo Miller	3724 Marathon Drive
<i>Alice Bergman</i>	Alice Bergman	345 W. 1st St. Billings
<i>Elsa D. French</i>	ELSA D. FRENCH	424 N. 3rd St. Biggs
<i>Betty L. Eichhorn</i>	Betty Eichhorn	5028 Raven Rd. Helena
<i>Ethel Ellis</i>	ETHEL ELLIS	Brookside, MT.
<i>Betty Grayson</i>	Betty Grayson	215 North - Biggs
<i>Ann Loischer</i>	Ann Loischer	1113 Forrest Ave
<i>Kim Love</i>	Kim Love	1306 Lewis Biggs, MT. 59102
<i>Andrey Hensiek</i>	Andrey J. Hensiek	3031 Boulder # B-3 Billings, MT 59102
<i>Marie Rall</i>	Marie Rall	718 Haugen St. Biggs
<i>Mary Hanks</i>	Mary Hanks	1130 - N. 23rd St. Biggs
<i>Karen Starling</i>	Karen Starling	3563 Cambridge
<i>Doris Hamilton</i>	Doris Hamilton	334 Ave. C - Billings

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<i>[Signature]</i>	William H. H. H.	Billings, Mt.
<i>[Signature]</i>	Barbara B. Baker	Box 1 - Durand, MT
<i>[Signature]</i>	Bill Lund	Box 31 Red Lake, MT
<i>[Signature]</i>	Ed Ryan	158 Constitution Ave, Billings
<i>[Signature]</i>	Thomas Peterson	1339 4th Ave, Billings
<i>[Signature]</i>	Timothy Sinner	2020 13th St, Billings
<i>[Signature]</i>	Fanny Rane	3406 Lakewood Blvd
<i>[Signature]</i>	Colin P. Potts	3015 8th Ave, Billings
<i>[Signature]</i>	MARY A MAGGARD	1142 3rd Street
<i>[Signature]</i>	Ed MANNING	4520 Humphrey
<i>[Signature]</i>	Suzanne Hoot	825 Parkview
<i>[Signature]</i>	Suzanne Hoot	1030 N. 30th
<i>[Signature]</i>	Willa Weaver	940 1/2 N. 7th
<i>[Signature]</i>	Felix S. Webb	#16 Heathman
<i>[Signature]</i>	MARY WEBB	" "
<i>[Signature]</i>	John R. Butler	525 S. Main Dr.
<i>[Signature]</i>	Thelma (McDonnell)	1017 8th Ave - Billings
<i>[Signature]</i>	Raymond J. Leone	3016 Birch St, Billings
<i>[Signature]</i>	CHAD SHIELDS	845 TERRY AVE.
<i>[Signature]</i>	Charles Shields	3295 George Ave E + 1/2
<i>[Signature]</i>	G. W. Shields	840 Terry
<i>[Signature]</i>	EVA M. STEER	3849 Main St
<i>[Signature]</i>	JOHN TRETIN	909 WICKS LN
<i>[Signature]</i>	DeAnn Dawson	Molt Mont.
<i>[Signature]</i>	Gloria Hardy	Billings, Mt.
<i>[Signature]</i>	MARY A. BELLARD	Shepherd Hill
<i>[Signature]</i>	Angela M. Reichert	1741 Cody Dr, Boz.
<i>[Signature]</i>	Bonnie P. Price	132 Wyoming
<i>[Signature]</i>	Dawn M. Stract	331 6th
<i>[Signature]</i>	CONNIE L. DYKE	971 Neptune
<i>[Signature]</i>	Evelyn H. Hanson	Box 216 - Joliet, MT

We, the undersigned, do hereby support the passage of SB 340 - the Certification of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON remuneration for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
Mary Ann Morgan	Mary Ann Morgan	3933 Maple Heights
Jack B. Morgan	Jack B. Morgan	" "
Paul Morgan	Paul T. Morgan	1702 Peachtree St. NW
Robert Morgan	Robert Morgan	2120 Hedden Road
Joseph Tracy Morgan	Joseph Tracy Morgan	3200 University Blvd. Billings
Timothy D. Foster	Timothy D. Foster	3000 14th St. #12
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Katherine French	Katherine French	2203 Green St.
John Justin Sullivan	John Justin Sullivan	1000 Powder Mill Rd.
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Terry Palen	Terry Palen	1620 Janest St. Bldg
Sharon Palmer	Sharon Palmer	2010 14th St. Bldg
Ken Toland	Ken Toland	1916 14th St.
Theresa Light	Theresa Light	3001 11th Ave N
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Steve Meeks	Steve Meeks	7208 Elm
Linda Baugh	Linda Baugh	2441 Teton Ave. 59102
Margaret S. English	Margaret S. English	825 13th St. Billings, MT
Dorothy E. Hask	Dorothy E. Hask	1112 Keotena, Bldg 177
Michelle Shue	Michelle Shue	1121 14th Ave. 59105 mt
Christine O'Leary	Christine O'Leary	1000 14th St. Bldg 147
Lance R. Hendricks	Lance R. Hendricks	1340 Conesoma Line
Beverly Tieszen	Beverly Tieszen	1627 Yellowstone
Angela Erickson	Angela Erickson	815 Wyoming Ave.
George Frossa	George Frossa	3200 14th St. Bldg 147
Kathy A. Langworthy	Kathy A. Langworthy	3215 14th St. Bldg 147
Edith C. Hayles	Edith C. Hayles	2122 Trails End 59102

We, the undersigned, do hereby support the passage of SB 770 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS	Billings
Mary P. Schneider	MARY P. Schneider	919 Ave E	MT.
Nik. Schneider	Nik. Schneider	919 Ave E	Billings 89
Hermon Schneider	Hermon Schneider	1012 11th St.	Billings
W. H. Schneider	W. H. Schneider	4025 11th St.	Billings
Lynette Felt	Lynette Felt	1012 11th St.	Billings
Shirley Felt	Shirley Felt	1012 11th St.	Billings
Jim Becker	Jim Becker	1838 Broadway	Billings
Bruce Bennett	Bruce Bennett	1029 Valley Drive	Billings
Betty M. Callum	Betty M. Callum	1709 Broadway	Billings
Elizabeth Grass	Elizabeth Grass	37 Clark - Bldg 57	Billings
Viola Rudy	Viola Rudy	1115 Dana	Billings
Mary Dell Ellis	Mary Dell Ellis	Broadway 593	Billings
Sam Ellis	Sam Ellis	Broadway 593	Billings
Tim Casero	Tim Casero	1313 Main	Billings
Nancy Casero	Nancy Casero	1313 Main	Billings
Paul B. Batten	Paul B. Batten	P.O. Box 47	Billings
Harold B. Batten	Harold B. Batten	2112 Zuni	Billings
Mike Ryan	Mike Ryan	2938 St. Johns	Billings
Tammy Lee Charles	Tammy Lee Charles	3381 Branger Ave E.	Billings
Charles A. Farnen	Charles A. Farnen	1731 Yellowstone	Billings
Pamela C. Pace	Pamela C. Pace	2830 Oakland #37	Billings
Cindy Hask	Cindy Hask	1423 Grand Ave	Billings
Ellen Lassiter	Ellen Lassiter	1236 Reece Dr	Billings
Carol Patrowitz	Carol Patrowitz	619 Ave B Bldg	Billings
George B. Bledsoe	George B. Bledsoe	3030 Sunset Lane	Billings
Margaret Martin	MARGARET M. Bledsoe	3039 Remart Place	Billings
Margaret Martin	Margaret Martin	4443 Talisades Park	Billings
Michael A. Luster	Michael A. Luster	2917 Terry Ave	Billings
B. Schultz	B. Schultz	1816 Hickman	Billings
Pon Schunk	Pon Schunk	6942 Shepherd Pkwy	Billings
Mr. & Mrs. Frank Von Zuercher	Frank Von Zuercher	934 Cedar Ave	Billings

We, the undersigned, do hereby support the passage of SB 220 - the Certain of Health Care (COH) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CSI reimbursement for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<i>Pete Sanchez</i>	Pete Sanchez	36 McArthur
<i>K. F. Smith</i>	K. F. Smith	1000 1st St. Billings, MT
<i>Dorlene Luman</i>	Dorlene Luman	1807 Polk Ave. DN
<i>Frances Vincellette</i>	FRANCES VINCELETTE	2314 MILES AVE
<i>Lee Myers</i>	LEE MYERS	31-36th St. W.
<i>Linda E. Myers</i>	Linda E. Myers	31-36th St. W. Bldg.
<i>Vionne M. Stoltenberg</i>	VIONNE M. STOLTENBERG	1240 HARRARD
<i>Sister Dorothy</i>	SISTER DOROTHY	1134 Y. St.
<i>Adam L. Schurr</i>	ADAM L. SCHURR	2605 MAIN ST. SO.
<i>1741 Wicks Lane</i>		1741 WICKS LANE EGS.
<i>1041 Wicks Lane</i>		1041 WICKS LANE BUNKERS MT
<i>David Hobert</i>	DAVID HOBERT	581 ADAMS AVE.
<i>Herbert Tilley</i>	HERBERT TILLEY	511 N. JOHN ST.
<i>Mary Kelly</i>	Mary Kelly	Alameda 1010
<i>Geraldine Mulhey</i>	Geraldine Mulhey	4125 C. T.
<i>Laura Weber</i>	LAURA WEBER	2100 1st St. Bldg.
<i>Ed Kraft</i>	Ed Kraft	7438 Nebraska St.
<i>Adeline Bonn</i>	Adeline BONN	2227 Oak
<i>Sandra M. Almond</i>	Sandra M. Almond	3006 Aljama Ave
<i>James B. Almond</i>	James B. Almond	3206 Aljama Ave.
<i>James Almond</i>	James Almond	622 Oakmont St.
<i>Kelly Campbell</i>	Kelly Campbell	1022 Oakmont St.
<i>Billie O. Walker</i>	Billie O. Walker	35 Prince Albert
<i>Gene Harn</i>	Gene Harn	428 Custer
<i>Frances Hecker</i>	Frances Hecker	Montana, MT
<i>Victoria L. Ullman</i>	Victoria L. Ullman	910 10th St. W. H226
<i>Valerie J. Geist</i>	VALERIE J. GEIST	274 Sunbeam Drive
<i>Aletha Dietrich</i>	Aletha Dietrich	1423 8th St. W. Bldg.
<i>Diana P. Johnson</i>	DIANNA P. JOHNSON	2519 Coker Bldg.
<i>Penny Barnard</i>	Penny Barnard	RT 1 LAUREL MT
<i>James A. Borer</i>	James A. Borer	109-19th W. Bldg.

We, the undersigned, do hereby support the passage of SB 270 - the Certification of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON certification for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
[Signature]	Loana H. [unclear]	[unclear]
[Signature]	Edna [unclear]	[unclear]
[Signature]	Loetta E. [unclear]	[unclear]
[Signature]	Elizabeth Labrenz	2403-10 th Ave. SE
[Signature]	James Bell	[unclear]
[Signature]	Isolina A. Stanley	[unclear]
[Signature]	John P. [unclear]	[unclear]
[Signature]	William H. [unclear]	[unclear]
[Signature]	James T. [unclear]	[unclear]
[Signature]	MARIE [unclear]	[unclear]
[Signature]	MARY BETH EBEL	709 E. [unclear] MT. 59144
[Signature]	W. Lee [unclear]	Bozeman
[Signature]	[unclear]	[unclear]
[Signature]	RE [unclear]	Bozeman mt
[Signature]	[unclear]	Bozeman, MT 59105
[Signature]	ROSE M. MATOCH	Bozeman MT 59105
[Signature]	Geraldine Cross	16 Camino [unclear]
[Signature]	Linda [unclear]	5557 [unclear]
[Signature]	Carol [unclear]	[unclear]
[Signature]	TIMOTHY BIRKLE	Bozeman MT 59105
[Signature]	AL [unclear]	Bozeman MT 105
[Signature]	Barbara Wiley	Billings MT 59102
[Signature]	JOAN [unclear]	1841 [unclear] Dr. Billings, MT 59102
[Signature]	Zeda [unclear]	804 Parkhill Billings, MT 59102
[Signature]	RENT T. SWIFT	1232 St. Johns Billings, MT 59102
[Signature]	JONES O. [unclear]	2614 [unclear] Billings, MT 59102
[Signature]	Dona M. Kruse	576 Railroad Hwy Huntley, Montana 59
[Signature]	Scott [unclear]	1841 [unclear] Dr. Billings, MT 59105
[Signature]	LORRAINE [unclear]	2702 [unclear] Dr. Billings, MT 59105
[Signature]	Eloise Y. Nead	707 Howard Ave. Billings, MT 59105
[Signature]	ILR WHITE	1638 HOWARD AVE.

We, the undersigned, do hereby support the passage of SB 340- the Certificate of Need (CON) compromise bill introduced by Senator Williams-at the request of the Montana Hospital Association. This bill recommends the elimination of CON requiation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<i>Dorothy J. Metz</i>	Dorothy J. Metz	Billings
<i>Theresa H. Johnson</i>	Theresa H. Johnson	Billings
<i>Margaret E. Shiff</i>	MARGARET E. SHIFF	Billings
<i>Jessie B. Boyce</i>	TESSIE B. BOYCE	Billings
<i>Margaret E. Shiff</i>	MARGARET E. SHIFF	Billings
<i>Florence N. Wadnick</i>	FLORENCE WADNICK	Billings
<i>Mary E. Larson</i>	MARY E. LARSON	Billings
<i>Dee Anne Mellen</i>	Dee Anne Mellen	Blgs
<i>Roberta Sullivan</i>	Roberta Sullivan	Billings
<i>Robert J. McDermott</i>	Robert J. McDermott	Billings
<i>Charlotte Smith</i>	CHARLOTTE B. SMITH	Billings
<i>Laverne L. Daly</i>	LAVERNE L. DALY	Billings
<i>Edith Carlson</i>	EDITH CARLSON	Billings
<i>Mary Nelson</i>	MARY NELSON	Billings
<i>E. Jeanne Erickson</i>	E. JEANNE ERICKSON	Billings
<i>Chaire Center</i>	Chaire Center	Billings
<i>Jean Wallis</i>	Jean Wallis	Billings
<i>Chaire Center</i>	CHAIRE CENTER	Billings
<i>Monica Chesarek</i>	Monica Chesarek	Billings
<i>Jane M. Amster</i>	JANE M. AMSTER	Blgs
<i>Flemon Walton</i>	FLEMON WALTON	Blgs
<i>Constance Pedroni</i>	Constance Pedroni	Blgs
<i>Lorraine Tarmann</i>	Lorraine Tarmann	Blgs
<i>Dorothy Leone</i>	Dorothy Leone	Blgs
<i>Elsie Fergus</i>	Elsie Fergus	"
<i>Edith Allan</i>	Edith P. Allan	"
<i>Jean Honer</i>	Jean Honer	Blgs
<i>Louise H. Back</i>	Louise H. Back	"
<i>Sister Amy Wilcox</i>	Sister Amy Wilcox	Billings
<i>Spencer J. Watson</i>	Spencer J. Watson	Billings

PETITION

Page 17 of

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<i>Mary Jane Tour</i>	Mary Jane Tour	201 1/2 N. 1st St. Billings, MT 59101
<i>Ron Fisher</i>	Ron Fisher	2225 Willoughby Billings, MT 59102
<i>Sandra McKee</i>	Sandra McKee	1430 1st St. N. Billings, MT 59101
<i>Phyllis Farnen</i>	Phyllis Farnen	471 1st St. N. Billings, MT 59101
<i>Barbara Farnen</i>	Barbara Farnen	471 1st St. N. Billings, MT 59101
<i>Charles Deutscher</i>	CHARLES DEUTSCHER	734 HUBB Billings, MT 59101
<i>Don Buckley</i>	Don Buckley	4129 King Ave East Billings, MT 59101
<i>Lynne Koepfner</i>	Lynne Koepfner	1027 Oakwood Billings, MT 59101
<i>John W. Farnen</i>	John W. Farnen	2100 1st St. N. Billings, MT 59101
<i>Barbara Farnen</i>	Barbara Farnen	471 1st St. N. Billings, MT 59101
<i>J. S. Surobada</i>	J. Surobada	3610 7th St. N. Billings, MT 59101
<i>FAY MARSH</i>	FAY MARSH	2020 Parkhill Dr. Billings, MT 59101
<i>ILLI HENB</i>	ILLI HENB	458 Beverly Hill Blvd, 59101
<i>CONNIE SPANSON</i>	CONNIE SPANSON	310 N. 35th St. S. 59101
<i>GARY HOFFMANN</i>	GARY HOFFMANN	3759 LAUREL 59101
<i>Janice Tomaszky</i>	Janice Tomaszky	3298 51st Street, 59101

EXHIBIT 7

DATE 3-3-89

HB 340

PETITION

Page 1 of 2

We, the undersigned, do hereby support the passage of SB 356 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<i>Louise Howell</i>	Louise Howell	Home - 1000
<i>Mary Eggum</i>	Mary Eggum	Box #6 Warden
<i>Sally Crawford</i>	Sally Crawford	2511 1st St. W. Helena
<i>Mildred Warren</i>	Mildred WARREN	213 Central St. Helena
<i>Joan Fifield</i>	JOAN Fifield	1538 Howard

EXHIBIT 7
 DATE 3-3-89
 HB 340

PETITION

Page 19 of

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE

PRINTED NAME

ADDRESS

SIGNATURE

PRINTED NAME

ADDRESS _____

Ken Bunt

XEN BURT

1516 Cook

Gay Burt

Tudy Burt

1516 COOK

EXHIBIT _____

DATE _____

HB

SURGICAL ASSOCIATES, P.C.
GENERAL, VASCULAR AND THORACIC SURGERY
MEDICAL ARTS CENTER • 1230 NORTH 30TH STREET
BILLINGS, MONTANA 59101-0181

JOHN J. MCGAHAN, M.D.
ELMER E. KOBOLD, M.D.
JOHN H. COOK, M.D.
JOHN D. MIDDLETON, M.D.

TELEPHONE: (406) 252-8494

PETITION

Page 20 of

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<i>John J. McGahan</i>	John J. McGahan	3104 Gregory
<i>Elmer E. Kobold</i>	ELMER E KOBOLD	2500 Emerson B
<i>John D. Middleton</i>	John D. Middleton	5422 ...
<i>John H. Cook</i>	John H. Cook	1821 ...
<i>Dorinda L. Egan</i>	DORINDA L. EGAN	1226 ...
<i>Bonnie L. Whitman</i>	Bonnie L. Whitman	3637 ...
<i>Norris L. Matison</i>	NORRIS L. MATISON	510 ...
<i>George E. Hickman</i>	George E. Hickman	266 ...
<i>Exeter L. Hoffman</i>	Exeter L. Hoffman	2446 ...
<i>Julian Stenson</i>	JULIAN STENSON	2112 ...

EXHIBIT _____

DATE _____

HB _____

DONALD GREWELL, D.O.

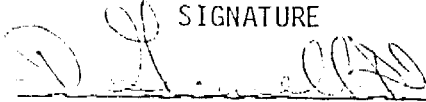
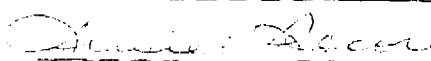
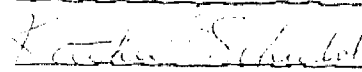
Family Practice
Medical Arts North
1232 North 30th Street
Billings, Montana 59101

Telephone (406) 256 1135

PETITION

Page 2 of

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
	Donald Grewell	1232 N. 30th St. Billings, MT
	Susan Socon	4313 Zephyrus Billings, MT
	Susan Socon	4313 Zephyrus Billings, MT
	Kathy Schult	1015 Patton St. Billings, MT

EXHIBIT

DATE

HB

PETITION

Page 22 of

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<i>Ramona Turnbull</i>	RAMONA TURNBULL	2009 Parkhill Dr. Salt Lake
<i>Joyce E. Shammel</i>	Joyce E. Shammel	417 Fairwood Blvd Brea
<i>L. Ann Hecchi</i>	L. Ann Hecchi	1060 Brown
<i>Gayle Langlois</i>	Gayle Langlois	1523 Wilke Ln.
<i>Ramona Ward</i>	Ramona Ward	233 1/2 Lewis Ave.
<i>S. P. Taylor</i>	S. P. TAYLOR	42116 Gate Road

EXHIBIT _____

DATE _____

HB _____

PETITION

Page 23 of _____

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON requirements for hospitals only.

SIGNATURE

PRINTED NAME

ADDRESS

SIGNATURE Jane Brosseau PRINTED NAME JANE BROUSSEAU ADDRESS 2114 9 Ave NW
Calgary, Alberta

EXHIBIT

DATE _____

HB.

PETITION

Page 20

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<u>Richard Anderson</u>	<u>Richard Anderson</u>	<u>1230 N 20th St</u>
<u>Armed T. Tregert</u>	<u>Armed Tregert</u>	<u>2223 N 1st St</u>
<u>Barbara M. M.</u>	<u>Barbara M. M.</u>	<u>1000 N 1st St</u>
<u>John A. Evans</u>	<u>John A. Evans</u>	<u>501 N 1st St</u>
<u>Janet A. Evans</u>	<u>Janet A. Evans</u>	<u>501 N 1st St</u>

EXHIBIT _____

DATE _____

HB _____

PETITION

Page 25 of

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<i>Neal B. Schensen</i>	NEAL B. SCHENSEN	1230 H. 30 74115
<i>Ulu Benjamin</i>	Celie Benjamin	1230 N. 30 BILLINGS
<i>Pamela J. Schied</i>	Pamela J. Schied	1230 N 30 14711
<i>Phyllis Whitwell</i>	Phyllis Whitwell	733 Ave A D
<i>Patrick Pryor</i>	J. PATRICK PRYOR	1230 N. 30 74115
<i>Benjamin T. Harrell</i>	Benjamin T. Harrell	1230 N 30 74115
<i>Robert B. Buehler</i>	Robert Buehler	1230 N 30 74115
<i>Shirley Dyer</i>	Shirley Dyer	1230 N 30 74115
<i>Dawn Laemmle</i>	Dawn Laemmle	PO Box 497 Shelby, MT
<i>Marion Tehau</i>	Marion Tehau	2035 Willow
<i>Paula Buehler MD</i>	Paula Buehler	1230 N 30 m. Billings, MT
<i>Sandy Vincent</i>	SANDY VINCENT	2046 LILLIS LN
<i>Debra Gher</i>	Debra Gher	2913 Gust. B.
<i>Paula Ludlum</i>	Paula Ludlum	3118 Marguerite Bl.
<i>Gloria Jansma</i>	Gloria Jansma	7583 KELLER RD LAUREL, MT 59044
<i>Laurence Faught</i>	LAURENCE FAUGHT	2522 CLARK S.

EXHIBIT

DATE

HB

PETITION

Page 10 -

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON application for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<u>Neil E. Meyer</u>	<u>NEIL E. MEYER</u>	<u>3141 1st St. N.</u>
<u>Denise L. Renny</u>	<u>DENISE L. RENNY</u>	<u>441 Burlington Blvd.</u>
<u>Kira H. Dodman</u>	<u>Kira H. Dodman</u>	<u>707 1st St. N.</u>

EXHIBIT

DATE

HB

PETITION

Page 27

We, the undersigned, do hereby support the passage of SB 1372 - the Certification of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE

PRINTED NAME

ADDRESS

SIGNATURE	PRINTED NAME	ADDRESS
James O. LeRoh	James O. LeRoh	1457 17th St. S.E.
Susan L. LeRoh	Susan L. LeRoh	4941 Tenth St. N.E.
Kathryn J. LeRoh	Kathryn J. LeRoh	4941 Tenth St. N.E.
Russell L. LeRoh	Russell L. LeRoh	2222 14th St. S.E.
Carl LeRoh	Carl LeRoh	1457 17th St. S.E.
Gene Meyer	Gene Meyer	902 1st St. S.E.
Fred Schneider	Fred Schneider	3527 Tenth St. N.E.
Robert M. Hill	Robert M. Hill	1332 7th St. S.E.
William L. LeRoh	William L. LeRoh	1222 14th St. S.E.

~~EXHIBIT~~

DATE _____

PETITION

Page 25

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<i>Mary Jo Gregory</i>	MARY JO GREGORY	8116 Terry Blvd. Billings
<i>Pat Sharp</i>	PAT SHARP	15755 6th Avenue
<i>Karen Novasio</i>	Karen Novasio	1602 Clark Blgs 50
<i>Linda Luse</i>	LINDA LUSE	405 WEST 1ST ST. BLGS 51
<i>Nancy To-Kildson</i>	Nancy To-Kildson	1647 Rand Road #1. BLK
<i>Brenda L. Nagel</i>	Brenda L. Nagel	718 N 22 St. Blgs 50
<i>Charlene Speer</i>	CHARLENE SPEER	1506 TILLMAN BLVD
<i>Carol D. Allen</i>	CAROL D. ALLEN	4043 Washington St. Blgs 50
<i>Linda G. Rand</i>	LINDA G. RAND	3829 Rimrock Rd. Blgs 50
<i>Edward H. Brooks</i>	EDWARD H. BROOKS	816 5TH ST. Blgs 50
<i>Mary Krennik</i>	MARY KRENNIK	7135 Charlotte St. 5910
<i>Darla Huebner</i>	Darla Huebner	4216 Caravan Blgs 59
<i>Rosemary Olive</i>	Rosemary Olive	4903 Haines Rd. Sheridan 59
<i>Betsy K. Turner</i>	Betsy K. Turner	2215 Central Ave #15910
<i>Kathy Bennett</i>	Kathy Bennett	283 Aswan Pl. 59105
<i>Kick Macklay</i>	Kick Macklay	5422 Howard 59105
<i>Kim Lumbie</i>	Kim Lumbie	705 W. 1st St. 5910
<i>Glenn Jones</i>	Glenn Jones	3517 14th St. Blgs 5910

EXHIBIT _____

DATE _____

HB _____

PETITION

Page 27

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON application for hospitals only.

SIGNATURE

PRINTED NAME

ADDRESS

Tom Clark	Tom Clark	Tom Clark
John Clark	John Clark	John Clark
Robert Clark	Robert Clark	Robert Clark
John S. Lindsay	John S. Lindsay	John S. Lindsay
W. T. Massey	W. T. Massey	W. T. Massey
W. T. Massey	W. T. Massey	W. T. Massey
W. T. Massey	W. T. Massey	W. T. Massey
W. T. Massey	W. T. Massey	W. T. Massey
W. T. Massey	W. T. Massey	W. T. Massey

EXHIBIT _____

DATE _____

PETITION

Page 35 of

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE

PRINTED NAME

ADDRESS

<i>[Signature]</i>	L. J. BERTAGLIA	2920 RONAN DR
<i>[Signature]</i>	DOE CAROL	1459 P. MAHARISHI DR
<i>[Signature]</i>	WILDEGARD F. HANSEN	715 N. 33 rd
<i>[Signature]</i>	GARY MOLLET	1046 W. LOMA BLVD.
<i>[Signature]</i>	MARY LO HOLTBY	3254 GRAND BLVD.
<i>[Signature]</i>	ELSIE HEIDEMAN	3809 BRIDGEMAN BLVD.
<i>[Signature]</i>	FRANCES C. ALLEN	769 FALLON BLVD.
<i>[Signature]</i>	PATRICIA M. BENSKE	43 HOLLY BLVD.
<i>[Signature]</i>	R. W. CALKIN	1205 BENCH BLVD.
<i>[Signature]</i>	GERTRUDE M. CALKIN	1205 BENCH BLVD.

EXHIBIT _____
 DATE _____
 HB _____

PETITION

Page 37

We, the undersigned, do hereby support the passage of SB 340 - the Certified Need (CON) compromise bill introduced by Senator Williams at the request of Montana Hospital Association. This bill recommends the elimination of CON certification for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<i>Kathy Berscheid</i>	Kathy Berscheid	111 Hickory Blgs
<i>Frederick Kahn</i>	Frederick Kahn	3003 W. MacDonald
<i>Ronald Burnam</i>	RONALD BURNAM	5506 Billy Casper
<i>Judith V. Burnam</i>	JUDITH V. BURNAM	5506 BILLY CASPER
<i>Joanne M. Meyer</i>	Joanne M. Meyer	3501-UNION CIR
<i>Marilyn Wheeler</i>	Marilyn Wheeler	1200 Clark
<i>Arthur Echeverri</i>	ARTHUR ECHEVERRI	3114 LeAnn
<i>Kelly Castro</i>	Kelly Castro	4644 R. H. B.
<i>Vickie Martin</i>	Vickie MARTIN	4522 S. Lewis
<i>Lori Hodges</i>	Lori Hodges	5454 GRANGER RD
<i>Audra Harkins</i>	Audra Harkins	100 Park St
<i>William H. Smoot</i>	William H. Smoot	1145 N. 29 TH ST
<i>Tammy V. Baines</i>	TAMMY V. BAINES	1123 N. D. M.
<i>Richard A. Hurd</i>	Richard Hurd	1120 N 31ST ST
<i>Thomas Thigpen</i>	Thomas Thigpen	2506 W. D. M.

EXHIBIT _____

DATE _____

PETITION

Page 32

We, the undersigned, do hereby support the passage of SB 370 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON limitation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<i>[Signature]</i>	L. H. [unclear]	[unclear]
<i>[Signature]</i>	Gregory [unclear]	[unclear]
<i>[Signature]</i>	Marlys Meyer	Billings MT
<i>[Signature]</i>	DAVID [unclear]	Billings MT
<i>[Signature]</i>	[unclear]	[unclear]
<i>[Signature]</i>	Andrea Martine	[unclear]
<i>[Signature]</i>	Brenda Kopp	Bliss MT
<i>[Signature]</i>	HADSON [unclear]	[unclear]
<i>[Signature]</i>	Patrick Grimsley	Bliss MT
<i>[Signature]</i>	Nitch Callagher	Bliss MT

EXHIBIT _____
 DATE _____
 HB _____

PETITION

Page 12

We, the undersigned, do hereby support the passage of SB 370 - the Certification of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE

PRINTED NAME

ADDRESS

<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>
<i>[Signature]</i>	N. V. KOLVIN	2013 Foust St. E.
<i>[Signature]</i>	JILL GILLETTE	2930 FOSTER ST.
<i>[Signature]</i>	BT WIEBIZ	416 S. HANCOCK ST.
<i>[Signature]</i>	D. R. LANDRUM	717 W. 2nd St. Helena
<i>[Signature]</i>	J. L. KNIGHT	135 W. 2nd St. Helena
<i>[Signature]</i>	W. G. SHARP	106 19th St. Helena
<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>

EXHIBIT

DATE

We, the undersigned, do hereby support the passage of SB 170 - the Certification of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON certification for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<i>Harold B. Mueller</i>	HAROLD B. MUELLER	7141 Yellowstone Dr. Boz.
<i>Trygve Hure</i>	TRYGVE HURE	1269 PRICETTES BLVD
<i>Jerri Dawson</i>	JERRI DAWSON	5216 57th St.
<i>Marilee Barker</i>	MARILEE BARKER	3411 5th Ave. N. Missoula
<i>Speed T. Leary</i>	SPEED T. LEARY	7202 North 1st Ave. Boz.
<i>Donald Powers</i>	DONALD POWERS	4537 TOYON DR BOZEMAN

EXHIBIT

DATE

HB

PETITION

Page 35 of 35

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE

PRINTED NAME

ADDRESS

William B. Lyons William B. LYONS 234 FAIR PARK DR
Gerald L. Murphy Gerald L. Murphy 420 Nelson St.

We, the undersigned, do hereby support the passage of SB 346 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<i>Cheryl Oliver</i>	Cheryl Oliver	1254 Yellowstone #C4
<i>Kathy A Jones</i>	Kathy Jones	4129 Robin Lane
<i>George Angeles</i>	GEORGE ANGELES	2010 Northridge Billings MT
<i>Bernice Larson</i>	BERNICE LARSEN	2114 Silver Sage Trail Billings MT
<i>Marg McPhail</i>	Marg McPhail	4439 Audubon Way- Billings
<i>Sue Zeck</i>	Sue Zeck	484 Cunningham
<i>Chloe Houchen</i>	Chloe Houchen	1824 Columbia
<i>Martin Fisher</i>	MARTIN FISHER	1116 N 30th Bldg
<i>Sue K. Kinn</i>	Sue K. Kinn	1351 Hardrock Lane Bldg
<i>Walter Brown</i>	W. Brown	411 Stillwater
<i>Eric D. Jensen</i>	Eric D. Jensen	165 Wicksa Ct Bldg
<i>Troy Scribner</i>	TROY SCRIBNER	2040 BURSTED #20 Bldg MT
<i>Jeanne Kahle</i>	Jeanne Kahle	3127 35th W Bldg MT
<i>Lo Oberwaser</i>	Lo Oberwaser	7105 Opaskoos Rd
<i>Ardella Mack</i>	Ardella Mack	1218 Shepherd St W Bldg MT
<i>Joanne Card</i>	Joanne Card	2207 Pueblo Dr
<i>D. Eugene Fletcher</i>	D. Eugene Fletcher	1119 Primrose Billings MT

EXHIBIT

DATE

HB

We, the undersigned, do hereby support the passage of SB 100 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<i>W. Terry Orr</i>	W. Terry Orr	4001 Park Dr SE, 10 Billings, MT 59101
<i>William D. Reelle</i>	WILLIAM D REELLE	1430 GARFIELD AVE BILLINGS MT 59102
<i>LeRoy E. Stewart</i>	LeRoy E. Stewart	1704 CENTRAL BILLINGS, MT 59102

EXHIBIT _____
DATE _____
HB _____

PETITION

Page 37 of

We, the undersigned, do hereby support the passage of SB - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
<i>Kirk Hodges</i>	KIRK HODGES	2040 BURNSTADT
<i>James C. Young</i>	James C Young	133 Ave B
<i>Kathy Knapton</i>	Kathy Knapton	5740 N. 1st
<i>Douglas C. Horton</i>	Douglas C Horton	261 West 1st
<i>Robert L. Lake</i>	Robert L. Lake	5740 N. 1st
— (647) to here —		

EXHIBIT

DATE

PETITION

Page 46 of

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE

PRINTED NAME

ADDRESS

<u>Diane J. Taylor</u>	DIANE TAYLOR	3221 ARVIN, BLK
<u>Linda Schatz</u>	LINDA SCHATZ	3015 GILMAN ST
<u>Theresa Boastad</u>	Theresa Boastad	2931 Nettle Rd
<u>Pam Jones</u>	Pam Jones	4629 Robble
<u>Debra Maheen Smith</u>	Debra Maheen Smith	70 Macias
<u>Hazel Brewer</u>	Hazel Brewer	10 Buchanan
<u>Vivian Norstrom</u>	VIVIAN NORSTROM	2016-13 th St. W
<u>Ellen Stroebel</u>	ELLEN STROEBEL	2107 Elm St
<u>Margaret A. Bayne</u>	MARGARET A. BAYNE	3308 K. Ave. N
<u>Louise Nichols</u>	Louise Nichols	Box 436 Laramie, WY
<u>Dorothy D. Murray</u>	Dorothy D. Murray	3435 J Street Ft. Collins, CO
<u>Ruth D. Harvey</u>	Ruth D. Harvey	2207 Spruce St.
<u>Anne Hill</u>	Anne Hill	1930 Forest Pl. Dr
<u>Kathryn Wilson</u>	Kathryn Wilson	1146 Delphinium Dr
<u>Margaret Thomas</u>	Margaret Thomas	2931 Lewis Ave
<u>John T. McGahan</u>	John T. McGahan	3104 Gregory Rd
<u>Louise Murray</u>	Louise Murray	105 Ave E
<u>Kate Dorsey</u>	Kate Dorsey	210 5th St
<u>Sam Beemansick</u>	Sam Beemansick	511 Fuller Circle
<u>Evelyn Funk</u>	Evelyn Funk	3009 University St
<u>Donald Brown</u>	Donald Brown	1043 1/2 Terry
<u>Evelyn C. Svingen</u>	Evelyn C. Svingen	2730 Downer Ln
<u>Bruce H. Abbott</u>	Bruce H. Abbott	2006 Stue D. Hilling
<u>Hazel Henry</u>	Hazel Henry	906 1 st Ave. - Lawe
<u>Robert T. Henry</u>	Robert T. Henry	911 1st Ave. - Lawe

PETITION

EXHIBIT _____

DATE _____

HB _____

Page 42

We, the undersigned, do hereby support the passage of SB 340- the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE

PRINTED NAME

ADDRESS

Wayne Melker	WAYNE MELKER	Kinsley MT 59101
BENITO MIRANDA	BENITO MIRANDA	1001 S. 1st St.
MARY O. BUTLER	MARY O. BUTLER	5250 1st St.
VIRGINIA TENGE	VIRGINIA TENGE	2410 1st St.
JOHN E. TENGE	JOHN E. TENGE	
ROSS LEMKE	ROSS LEMKE	301 S. 1st St.
Sylvia Turco	Sylvia Turco	2223-24th St.
RITA C. LEMIRE	RITA C. LEMIRE	-8810 Broadway
John Allen	John Allen	2410 1st St.
Ethel K. Hennrich	Ethel K. Hennrich	2138 1st St.
Dorothy Bennett	Dorothy Bennett	Box 330 1st St.
CINDY BENNETT	CINDY BENNETT	Box 330 1st St.
AMELIA C. HADLEY	AMELIA C. HADLEY	2526 1st St.
JENNIFER VASHRO	JENNIFER VASHRO	1101 S. 24th
JENNIFER M. MEYER	JENNIFER M. MEYER	1105 Sunnyvale Dr.
TOM PARTING	TOM PARTING	24 Broadway
Linda Guntrell	Linda Guntrell	1134 Harvard
Dr. Adolph	Dr. Adolph	703 1st St.
Laura J. Padke	Laura J. Padke	2013 1st St.
Beverly Dunn	Beverly Dunn	603 1st St.
Sister Mary Antoinette Thomas	Sister Mary Antoinette Thomas	100 1st St.
SISTER MARY ANN PETKICH	SISTER MARY ANN PETKICH	216 N. 31st St.
SISTER ROSEMARY KOLICH	SISTER ROSEMARY KOLICH	2703 1st St.
Sister Mary Kathleen	Sister Mary Kathleen	216 1st St.
JUDITH G. LORSEN	JUDITH G. LORSEN	674 Taylor

VISITORS' REGISTER

HUMAN SERVICES AND AGING

COMMITTEE

BILL NO. SB 340

DATE 3/3/89

SPONSOR

NAME (please print)	REPRESENTING	SUPPORT	OPPOSE
<i>Jim Shum</i>	Mont Hosp Assoc	✓	
L. McEVOY	Mont Assoc. Phys	✓	
<i>Jim Papette</i>	Trinity Hospital with Pont	✓	
<i>John Boguth</i>	St. Vincent Hosp.	✓	
COLLEN K. NORTHAM	SAINT VINCENT HOSPITAL	✓	
Sandra Erickson	Providence tx Center-Gt Falls Chemical Dependency Programs of Mt	✓ with amendment	
<i>Leo Patton</i>	AARP	Amendment	
Owen Warren	AARP	Amendment	
<i>Ann Warren</i>	AARP	Amendment	
Charles Pagano	Dept of Health & Environmental Sciences		
Jack Casey	Shoemaker Hosp.	✓	
<i>Jenny Beaumont</i>	Shenandoah Memorial Hosp	✓	
<i>Ed Shreeley</i>	NARPE	✓	
Richard Brown	Liberty County Hospital	✓	
Jean G. Weeks	Volunteers St Peter	✓	
JOHN GUY	ST PETER'S HOSP	✓	
Jean Ashley	MHCN COUNTRY COUNSEL/SECRET HOME	with amendment ✓	
LARRY ACEY	MT. HEALTH NETWORK	✓	
<i>Don T. Zander</i>	Mt Patient Care	✓	
<i>Steve Waldman</i>	Mental Health Center	AMEND	
<i>Kathleen Lewis MD</i>	Private Medical Practices		
<i>Dale Josselyn</i>	North Valley Hospital, Whitefish	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED

STATEMENT WITH SECRETARY.

Ann Scott

RINTC

Rie Bellwood

Private Citizens

amend
amend

Steve Browning Montana Hosp
Asson

For

Ag

X